DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	R 06/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A revisit was completed at Laurelbrook Sanitarium on June 5, 2012, following acceptance of an Allegation of Compliance to remove the Immediate Jeopardy at F-223 and F-323, Scope and Severity level "K;" F-406, Scope and Severity level "J;" and F-226, F-490, F-501, and F-520, Scope and Severity level "L". The revisit revealed the corrective actions implemented May 30, 2012, removed the Immediate Jeopardy but non-compliance continues at an "E" level Scope and Severity for F-223 and F-323; at a "D" level for F-406; and at an "F" level for F-226, F-490, F-501, and F-520. Other deficiencies previously cited and not addressed on the Allegation of Compliance remain outstanding. The facility is required to submit a plan of correction for all outstanding deficiencies including the Immediate Jeopardy tags lowered in scope and severity.	{F 000}	All future hires to the nursing home will receive in-services stated for the deficiencies cited from this survey.	
{F 154} SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview,	{F 154}	**F 154 483.10 (b)(3), 483.10(d)(2) Informed of Health Status, Care & Treatment** **Resident #1** 1) The DON reviewed their policy and revised to ensure that all residents are informed if and when any drug screens are performed as ordered by the physician and the reason for the test. The DON conducted an in- service with all	6/6/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marvin Frey by Ron Overton — TITLE: President — (X6) DATE: 6-20-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		F 154	RNs and LPNs that all tests when ordered by the physician must be approved by the resident, their family, or POA prior to conducting any diagnostic lab test including drug screening on 5/22/12. The Medical Director was provided a copy of this policy on 5/29/12 to help ensuring residents or family members or POA are kept informed. The policy "Health and Medical Condition, Informing Residents of" was provided to each RN & LPN on 6/1/12 to reinforce the in-service conducted on 5/22/12. Exhibit # 36 **2)** On 5/29/12 all other residents who had lab work conducted within the month of May either the resident, family or POA had been informed of the lab work & this notification was documented in chart. On 6/1/12 all lab work ordered was documented in Medical Record based on chart audit conducted by LPN staff. On 6/1/12 the policy "Health and Medical Condition, Informing Residents of" was posted on the nursing's bulletin board as a reminder of facility	

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{F 154}	Continued From page 1 the facility failed to inform one resident (#1) of a laboratory test performed of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Interview with the Nursing Home Administrator (NHA) on May 7, 2012, at 1:50 p.m., in the NHA office, revealed a urine drug screen was completed on the resident on May 3, 2012, without the resident's knowledge or consent. Interview with the Director of Nursing (DON) on May 9, 2012, at 9:10 a.m., in the front lobby, confirmed the facility completed a urine drug screen on the resident without the resident's knowledge or consent. C/O #27265 #28092	{F 154}	practice. This policy will be in-serviced quarterly for the next 6 months beginning with 6/1/12. 3) The DON or designee will monitor all lab work ordered to ensure residents are aware of testing beginning 5/29/12. This policy "Health and Medical Condition, Informing Resident of" will be in-serviced quarterly for the next 6 months beginning 6/1/12. This policy will be part of orientation of new employees beginning 6/1/12. The DON or designee will monitor random lab work ordered by physician to ensure that the residents or their family or POA have been informed. This was begun on 5/29/12 and will continue weekly for 6 weeks then as needed to ensure compliance has been achieved.	
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in	{F 157}	4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next QAPI Committee is scheduled for 6/20/12.	

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{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in	{F 157}	**F 157 483.10(b)(11) Notify of Changes (Injury/Decline/Room, Etc)** 1) Upon being made aware of LPN #4's deficient practice of	6/6/12

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{F 157}	Continued From page 2 injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to notify the physician to receive an order for herbal medications for one resident (#20) of twenty-seven residents reviewed. The findings included: Resident #20 was admitted to the facility on May	{F 157}	administering herbal medication without a physician order, an in-service was conducted on the correct policy " Medication Family Supplied" stating that all medications must have a physician orders including herbal medications brought to facility by resident or family members. This was done on 5-15-12. The DON will observe LPN # 4 randomly on a monthly basis until no errors are noted. This was begun on 6/1/12. The Pharmacy Service was changed effective June 1, 2012. The Pharmacy Consultant will assist in capturing physician orders for all medications administered and recorded on MAR. Exhibit # 37 2) On 5/15/12 to 5/16/12 DON/ADON checked the other medication cart for all other residents to ensure no herbal medications were being administered without a physician order. No other residents were identified as needing an order. On 5/29/12 the RN/BSN staff in-serviced all other licensed staff on	

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{F 157}	Continued From page 3 1, 2012, with diagnoses including Anemia, Osteoporosis, Cerebral Vascular Accident, Transient Ischemic Attacks, and Cataract Repair. Observation on May 15, 2012, at 9:30 a.m., in the west hallway, revealed Licensed Practical Nurse (LPN) #4, preparing multiple herbal medications to administer to Resident #20, including Dandelion Leaf, Hawthorn Berry, Turmeric, Bilberry Leaf, and Vitamin C. Further observation revealed these medications were stored in zip lock bags labeled with the herbal medication name and strength, if applicable, and did not include the resident's name, medication expiration date, ordering physician's name, dispensing instructions, or pharmacy label. Medical record review of the Medication Administration Record for May 2012 revealed the resident received all the herbal medications daily from May 2 through 15, 2012. Medical record review of the physician's orders for May 2012 revealed no order from the resident's physician for the herbal medications. Interview on May 15, 2012, at 1:30 p.m., with LPN #2, at the nurse's station, confirmed the medications were brought to the facility in zip lock bags by the resident and the physician had not been notified to obtain an order for administration of the herbal medications.	{F 157}	"Verbal and Written Orders – General. 3) On 5/17/12-5/20/12, the ADON conducted a random sample of four licensed staff medication pass observation to ensure that the facility policy and state laws are observed including physician orders for all medications. The Pharmacy consultant will assist in Med Pass observations of RNs & LPNs administering medications within the facility beginning 6/1/12. The DON or designee will monitor medication administration to ensure resident's medications have physician orders. This was begun on 5/15/12 and will continue weekly for 4 weeks then monthly on a random basis to ensure compliance has been achieved. 4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next QAPI Committee is scheduled for 6/20/12.	
{F 164} SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	{F 164}		

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{F 164} SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.	{F 164}	F 164 483.10(e). 483.75(i)(4) Personal Privacy/Confidentiality of Records	6/6/12

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{F 164}	Continued From page 4 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide privacy during a treatment for one resident (#A) of five residents reviewed during medication pass. The findings included: Observation on May 15, 2012, at 8:10 a.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #2 failed to close the resident's	{F 164}	1) Upon being made aware of LPN #2's deficient practice of administering an insulin injection without providing privacy to the patient, an in-service was conducted with LPN # 2 on providing privacy when exposing any of a resident's body parts by closing door and curtains while administered medications. This was done on 5-15-12 by the DON. The DON/ADON will observe LPN # 2 randomly on a monthly basis until no errors are noted. This was begun on 6/1/12. The Pharmacy Consultant will assist in the observing RNs and LPNs during the Med Pass process beginning June 1, 2012 to ensure privacy is maintained. 2) On 5/15/12 to 5/29/12 ADON observed medication administration of all other residents to ensure privacy was provided. On 5/29/12 the ADON in-serviced all other licensed staff on the deficient practice observed by surveyors. The in-service consisted of the privacy of residents during treatment and administering medications that needed privacy.	

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		F 164	The "Quality of Life - Dignity" policy was given to each RN & LPNs with acknowledgement of receipt completed on 6/1/12. Exhibit # 38 **3)** Medication Pass will be observed by the DON or designee beginning 6/1/12 to ensure that the facility policy and state laws are observed concerning privacy of Residents during medication administration and treatment. The Pharmacy consultant will assist in Med Pass observations of RNs & LPNs during administration of medications within the facility beginning 6/1/12. The DON or designee will monitor medication administration to ensure resident's medications are given in private when resident's body parts are exposed. This was begun on 5/15/12 and will continue weekly for 4 weeks then monthly on a random basis to ensure compliance has been achieved. 4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the	

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{F 164}	Continued From page 5 room door and pull the window curtains closed during administration of insulin in the resident's abdomen with the resident's shirt pulled up to fully expose the bare abdomen. Further observation revealed staff and residents walked by the resident's room in the hallway and the resident's room window was within direct observation from the parking lot during the injection. Interview on May 15, 2012, at 8:20 a.m., with LPN #2, in the west hallway, confirmed privacy was not provided for the resident during the insulin administration.	{F 164}	Administrator will report to the Board quarterly. The next scheduled QAPI meeting is scheduled for 6/20/12.	
{F 166} SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to resolve a grievance for one resident (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the	{F 166}		

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{F 166} SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to resolve a grievance for one resident (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the	{F 166}	**F166 483.10(f)(2) Right to prompt efforts to Resolve Grievances** **1)** The grievance filed by Resident # 1 has been discussed with Resident #1 by the Administrator and his fan replaced on 6/1/12. An apology was provided to Resident # 1 for delay in addressing his complaint. The consultant Administrator assisting the facility Administrator conducted an in-service with the Administrator on the facility's compliance concerning investigation of grievances and documentation of investigation on 5/20/12. **2)** On 5/15/12 to all other residents were assessed for an unresolved	6/6/12

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{F 166}	Continued From page 6 resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Observation and interview with Resident #1 on May 7, 2012, at 10:50 a.m., in the resident's room, revealed two weeks ago the resident requested maintenance clean a fan belonging to the resident and when maintenance returned the fan to the resident it no longer worked. Continued interview at this time revealed the facility had not talked to the resident regarding the fan not working after being cleaned and the resident had reported the broken fan to the Administrator. Review of facility policy Filing Grievances/Complaints updated January 2000, revealed "...any resident may file a grievance...the allegation will be investigated...Administrator will review findings...determine what corrective actions...need to be taken...the resident will be informed of the findings..." Interview with the Administrator on May 7, 2012, at 1:50 p.m., in the Administrator's office, revealed the Administrator had been aware of the broken fan. Continued interview at this time confirmed the fan was not working when returned to the resident and the Administrator stated, "nothing but a liar, I refuse to talk to the resident about the fan, and I refuse to continue to write up grievances regarding this resident." Interview with the resident on May 15, 2012, at 3:00 p.m., in the physical therapy office, confirmed the facility had not discussed the grievance with the resident and the grievance	{F 166}	grievance. There were no other resident with unresolved grievances reported. A DON in-serviced all RNs, LPNs & CNAs on 5/29/12 concerning resident grievance process. The in-service consisted of "Grievance Policy". Any RN, LPN who have not attended the above in-service cannot work until they have attended an in-service on the Grievance Policy. Exhibit # 39 3) Grievance Investigations are conducted by the Administrator or DON beginning 5/29/12 to ensure that the facility policy and state laws are observed concerning Grievance by Residents. A log has been developed to track all grievances filed with Administration and an investigation has been conducted. The log book is kept by Social Services along with the investigations. 4) The Health Care Consultant will monitor the Grievances Investigated to ensure all resident grievances are logged and investigated. The monitoring was begun on 5/29/12	

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OMB NO. 0938-0391

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		F 166	and will continue weekly for 4 weeks then monthly on a random basis to ensure compliance has been achieved. The Administrator will report the outcomes of Grievance monitoring to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next QAPI Committee meeting is scheduled for 6/20/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{F 166}	Continued From page 7 was still unresolved. C/O #27265 #28092	{F 166}		
{F 172} SS=D	483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS The resident has the right and the facility must provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act); Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of	{F 172}	**F 172 483.10(j)(1) & (2) Right to /Facility Provision of Visitor Access** **1)** The DON in-serviced the MDS Coordinator on Resident Rights and reviewed the deficient practice that relates to the incident of Resident #1 not being allowed a visitor to visit or Resident leave with the visitor and taking the keys from the visitor on 5/16/12. The DON conducted an in-service with all RNs, LPNs and CNAs on Resident Rights 5/15/12, 5/24/12, & 5/28/12. **2)** On 5/15/12 to 5/29/12 all other residents were interviewed for violation of their rights. No other resident reported any violation of their rights. On 6/1/12 the policy "Resident Rights" was posted on the nursing's bulletin board as a reminder of facility practice. This policy will be in-serviced quarterly for the next 6 months beginning with 6/1/12 to all RNs, LPNs and CNAs.	6/6/12

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{F 172}	Continued From page 8 the resident. The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of Resident's Rights, and interview, the facility failed to provide visitor access for one resident (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Observation and interview on May 7, 2012, at 11:00 a.m., in the resident's room, revealed the resident sitting in an electric wheelchair. Interview at this time revealed the resident had a visitor on May 3, 2012, and the facility took the keys to the visitor's van to prohibit the resident from visiting and leaving the facility with the visitor.	{F 172}	Exhibit #40 Exhibit #67 3) The DON or designee will monitor for any violations of Resident's rights by interviewing all residents beginning 5/29/12 using the QIES survey document for Residents. This policy "Resident Rights" will be in-serviced quarterly for the next 6 months beginning 6/1/12. The DON will ensure this policy is a part of orientation of new employees beginning 6/1/12. The DON or designee will monitor residents randomly for any violations of Resident Rights. This was begun on 6/1/12 and will continue monthly for 3 months then as needed to ensure compliance has been achieved. 4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee is 6/20/12.	

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{F 172}	Continued From page 9 Telephone interview with a detective from the local county Sheriff's Department on May 8, 2012, at 1:50 p.m., revealed a 911 (emergency) call had been made to the Sheriff's Department from a visitor on May 3, 2012, stating the facility had taken the visitor's keys to the visitor's van and refused to allow the visitor to visit with the resident. Review of the facility's resident rights documentation in the admission packet, no date, revealed "...may have visitors...with persons of their choice..." Interview with the Administrator on May 7, 2012, at 1:50 p.m., in the Administrator's office, confirmed the facility had taken the visitor's keys on May 3, 2012, and denied the visitor access to the resident until the Sheriff's Department instructed the facility to give the keys back to the visitor. Interview with the MDS Coordinator on May 14, 2012, at 11:20 a.m., in the Director of Nursing's office, revealed the MDS Coordinator had taken the keys from the visitor of Resident #1. Continued interview at this time confirmed the facility failed to allow the resident access to the visitor.	{F 172}		
{F 221} SS=E	C/O #27265 #28092 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	{F 221}		

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{F 221} SS=E	C/O #27265 #28092 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	{F 221}	**F 221 483.13(a) Right to be Free From Physical Restraints** **Residents # 1, #2, #4, #10, #12, #14, #16, #17, #18, #19, #22, #26**	6/6/12

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{F 221}	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, medical record review, observation, and interview, the facility failed to complete a restraint assessment for twelve residents (#1, #2, #4, #10, #12, #14, #16, #17, #18, #19, #22, #26) and failed to obtain a physician's order for the use of restraints for four (#17, #14, #2, #4) residents of twenty-seven residents reviewed. The findings included: Review of the facility policy, "Restraint Use", revealed "...If evaluation shows the need for physical restraint the physician will be notified for direction/order...with use of any restraint the resident must be observed q (every) 30 minutes and position changed (at) least q 2 hours...Before any restraint orders are obtained, the following steps must be completed and the need deemed necessary. A restraint assessment, including alternatives must be completed..." Resident #17 was admitted to the facility on January 20, 2009, with diagnoses including Depressive Disorder, Severe Mental Retardation, and Convulsions. Medical record review of the Minimum Data Set (MDS) dated April 5, 2012, revealed the resident had severe impairment in cognitive skills. Medical record review of a Nursing Progress Note dated January 5, 2012, revealed "...MDS/Care Plan Quarterly Assessment	{F 221}	1) A Staff RN was assigned to complete a restraint assessment on the above residents beginning 5/15/12 and completed on 5/22/12. Those residents needing restraints an Informed Consent for restraints was obtained from the resident or his/her POA beginning 5/15/12 and completed on 5/29/12. If no physician order was on chart then the physician was informed and requested to sign the restraint order. The DON or RN BSN conducted an in-service with all RNs and LPNs on use of restraints - a pre-restraint assessment and an Informed Consent Signed by the resident, their family, or POA prior to placing a restraint unless it is an emergency. This was done on 5/28/12 & 5/29/12. The policy "Use of Restraints" was provided to each RN & LPN on 6/1/12 to reinforce the in-services conducted on the above dates. Any RN, LPN who have not attended the above in-service cannot work until they have attended an in-service on Use of Restraints. The MDS Coordinator reviewed and revised the above residents care plan	

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{F 221}	Continued From page 11 completed...continues to require the use of restraints for...safety (and) well-being. Reevaluated for the least restrictive type of restraint. Will continue with side rails up in bed x 2..." Medical record review of the MDS dated April 5, 2012, revealed no side rail used as a restraint. Medical record review of the care plan dated April 4, 2012, revealed "...Restraint: (resident) requires use of bil (bilateral) side rails up...reassess need for restraints Q (every) 3 months..." Medical record review of the Fall Risk Evaluation dated April 4, 2012, revealed the resident was at risk for falls. Review of the facility investigation dated July 25, 2011, revealed " ...Resident crawled to foot of bed (and) climbed out of bed between bed rail (and) foot of bed. Resident was observed on the floor. No injuries...approaches were in place at time of incident...Side rails x 2 up. Bed in lowest position...Bed alarm added to bed..." Observation on May 9, 2012, at 8:45 a.m., revealed the resident lying on the bed with full padded side rails in the raised position. Interview on May 9, 2012, at 9:50 a.m., with the Director of Nursing (DON), at the front desk, confirmed no physician's order had been obtained for the side rails and no assessment had been completed for the use of the side rails. Resident #22 was admitted to the facility on March 1, 2007, with diagnoses including	{F 221}	and MDS Assessment for needed changes or needed interventions. These changes were communicated to the RNs, LPNs and CNAs per memo and inservices. This was begun on 5/16/12 and completed on 5/31/12. On 5/29/12 the policy for obtaining the following assessments – Side Rail, Braden, Hydration, Bowel & Bladder, Elopement, Fall, Skin and AIMs if on psychoactive medication – was implemented 5/29/12 and if the assessment had not been conducted then the assessment was done. This was completed on 6/1/12 by licensed staff. An Admission Checklist was developed and approved by QA Committee on 5/29/12 to be used for newly admitted residents to ensure assessments were conducted on admission. Quarterly assessment will be conducted by the MDS Coordinator or designee. Exhibit #77 2) On 5/15/12 to 5/29/12 all other residents were assessment for side rails and other devices and any	

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{F 221}	Continued From page 12 Hypertension and Depression. Medical record review of the MDS dated April 19, 2012, revealed the resident had moderately impaired cognitive skills and bed rails used daily as a restraint. Observation on May 15, 2012, at 9:30 a.m., revealed the resident lying on the bed with bilateral full side rails in the raised position. Interview on May 15, 2012, at 12:00 noon, with the DON, in the front lobby, confirmed no assessment for the use of the side rails had been completed. Resident #2 was admitted to the facility on October 10, 2010, with diagnoses including Behavior Disorder, Alzheimer's Disease, and Dementia. Medical record review of the MDS assessment dated August 25, 2011, revealed the resident was severely cognitively impaired, had a history of wandering, and required limited staff assistance with ADLs (Activities of Daily Living). Continued MDS review revealed the resident was not coded for any type of physical restraint. Medical record review of the Care Plan (CP) dated February 21, 2012, revealed a care plan entry dated August 19, 2011, for weights to be added to the base of the merry-walker(an assistive device for ambulation). Continued CP review revealed an entry dated January 21, 2012, instructed side rails to be up bilaterally when in bed. Continued CP review revealed a care plan	{F 221}	resident needing a restraint, an Informed Consent for restraint was obtained from the resident or his/her POA beginning 5/15/12 and completed on 5/29/12. If no physician order was on chart then the physician was informed and requested to sign the restraint order. 3) The DON or designee will monitor residents daily for appropriate care and documentation beginning 5/29/12. This policy "Use of Restraints" will be in-serviced quarterly for the next 6 months beginning June 1st. This policy will be part of orientation of new employees beginning 6/1/12. The DON or designee will monitor use of restraint weekly then monthly for possible elimination or need for residents. This was begun on 5/15/12 and will continue weekly for 6 weeks then as needed to ensure compliance has been achieved. 4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly.	

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{F 221}	Continued From page 13 update dated January 30, 2012, to add a seatbelt to the merry-walker. Medical record review of a Nurse's Note (for resident #1) dated September 13, 2011, revealed "...(res #2) tried to climb over bed rails...assisted back in the bed..." No investigation or new interventions were documented. Resident #2's Nurse's Notes do not include notation of the resident attempting to exit the bed over the side rail. Observation of Resident #2 in the resident's room, on May 7, 2012, at 10:00 a.m., revealed the resident lying on the bed, with full side-rails up bilaterally. Observation on May 7, 2012, at 2:30 p.m., revealed the resident ambulating throughout the facility with a merry-walker. The resident had a seatbelt secured around the waist in the merry-walker, and the merry-walker had weights at the base to prevent the resident from tipping the device over. The resident was confused and mumbling to self. The resident could not exit the merry-walker independently when prompted. Observation on May 8, 2012, at 3:45 p.m., revealed the resident in the facility "circle area," in a reclined geri-chair with lap top tray secured across the lap. The resident was restless and attempting to exit the chair by leaning to the right. Interview with the DON, at the time of the observation, confirmed the recliner is a restraint with the tray table across the resident to prevent the resident from rising independently, the merry-walker and the seatbelt for the	{F 221}	**Resident #17, #14, #2, & #4** 1) A Staff RN was assigned to obtain a physician order on the above residents by 5/29/12. Those residents were also assessed for continued need for a restraint. If there was no Informed Consent for restraint then a consent was obtained from the resident or his/her POA beginning 5/15/12 and completed on 5/29/12. The DON or RN BSN conducted an in-service with all RNs and LPNs on use of restraints - a pre-restraint assessment and an Informed Consent Signed by the resident, their family, or POA prior to placing a restraint & order from Physician. This was done on 5/15/12, 5/24/12, 5/28/12, & 5/29/12. The policy "Use of Restraints" was provided to each RN & LPN on 6/1/12 to reinforce the in-services conducted on the above dates. Any RN, LPN who have not attended the above in-service cannot work until they have attended an in-service on Use of Restraints. The MDS Coordinator reviewed and revised the above residents care plan and MDS Assessment for needed	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 221}	Continued From page 14 merry-walker, as well as the bed side rails in the up position, are all physical restraints. The DON further confirmed the facility's restraint policy had not been followed, the comprehensive assessment was innaccurate, there was no Physician's Order, consent, or pre-restraint assessment related to the geri-chair with tray table, the merry-walker with seatbelt and weights, and the bed side rails. Resident #4 was admitted to the facility on June 2, 2008, with diagnoses including Schizophrenia, Depression, and Weakness. Medical record review of the resident's MDS assessment dated February 9, 2012, revealed the resident had severe cognitive deficits, the resident was ambulatory with the use of a walker, and the resident was not restrained. Observation of the resident on May 8, 2012, at 2:00 p.m., revealed the resident ambulating in the hallway with a walker and Physical Therapy providing stand by assistance. Observation of the resident on May 9, 2012, at 8:20 a.m., revealed the resident lying on the bed, with the left side of the bed against the wall and half side rails up, in the mid bed position, on the right side of the bed. Observation of the resident on May 14, 2012, at 10:05 a.m., revealed the resident lying on the bed, with the side rail on the right side of the bed in the down position. The left side of the bed was against the wall. Interview with the DON, on May 15, 2012, at	{F 221}	changes or needed interventions. These changes were communicated to the RNs, LPNs and CNAs per memo on 5/29/12. 2) On 5/15/12 to 5/29/12 all other residents were assessment for use of restraints, side rails and other devices by the assigned Staff RN. Any resident needing a restraint, an Informed Consent for restraint was obtained from the resident or his/her POA beginning 5/15/12 and completed on 5/29/12. If no physician order was on chart then the physician was informed and requested to sign the restraint order. The MDS Coordinator reviewed all other resident care plans and MDS Assessments for any needed changes or needed interventions. These changes were communicated to the RNs, LPNs and CNAs per memo on 5/29/12. 3) The DON or designee will monitor residents daily for appropriate care and documentation beginning 5/29/12. This policy "Use of Restraints" will be in-serviced quarterly for the next 6	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	R 06/05/2012

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{F 221}	Continued From page 15 11:25 a.m., at the nurse's station, confirmed the side rail on the right side of the bed is a restraint when in the up position, the left side of the bed was against the wall. The DON further confirmed the facility's restraint policy had not been followed, the comprehensive assessment was inaccurate, there was no physician's order, consent, or pre-restraint assessment related to the side rail. Resident #10 was admitted to the facility on June 23, 2008, with diagnoses including Schizophrenia, Dementia with Behaviors, and Mental Retardation. Medical record review of the resident's MDS assessment dated February 9, 2012, revealed the resident had severe cognitive deficits, and the resident required extensive staff assistance with all ADLs (Activities of Daily Living). The MDS included side rails and a chair to prevent rising coded as retraints. Medical record review of a Physician's Telephone Order dated February 26, 2012, revealed "...side rails X 2 (bilaterally) per family request for safety." Medical record review of the Care Plan dated February 21, 2012, revealed the resident was care planned for restraints, with the intervention of placing a tray table across the resident when seated in the geri-chair. The care plan was not updated to include the side rails. Observation of the resident on May 9, 2012, at 7:35 a.m., revealed the resident in the room seated in geri-chair with the tray table across the resident. The resident was confused and	{F 221}	months beginning June 1st. This policy will be part of orientation of new employees beginning 6/1/12. Exhibit #19 The DON or designee will monitor use of restraint weekly then monthly for possible elimination or need for restraints. This was begun on 5/15/12 and will continue weekly for 6 weeks then as needed to ensure compliance has been achieved. 4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is scheduled for 6/20/12.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 221}	Continued From page 16	{F 221}		

mumbling to self. The resident was unable to exit the chair when prompted.

Observation of the resident on May 9, 2012, at 10:00 a.m. revealed the resident in the room, seated in the geri-chair with the tray table across the resident, the resident was agitated and screaming incoherently.

Observation of the resident on May 14, 2012, at 2:20 p.m., revealed the resident in the "circle area " in the geri-chair with the tray table across the lap. The resident was confused and mumbling to self.

Interview with the DON, on May 14, 2012, at 2:25 p.m., at the nurse's station, confirmed the resident was restrained by the tray table and the facility's restraint policy had not been followed, there was no Physician's Order, consent, or pre-restraint assessment.

Resident #14 was re-admitted to the facility on January 31, 2011, with diagnoses including Personality Disorder, Dementia with Behavior Disorder, and Spinal Stenosis.

Medical record review of the MDS assessment dated February 9, 2012, revealed the resident had severe cognitive deficits, was chair or bed bound, was ambulatory with the use of a wheelchair, and was not restrained.

Medical record review the Care Plan revealed a restraint care plan had been implemented on October 7, 2010, and discontinued as "resolved" November 2010, due to the "...res (resident) now in gerri-chair."

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 221}	Continued From page 17	{F 221}		

Observation of the resident in the "circle area" on May 9, 2012 at 1:00 p.m., revealed the resident in a reclined geri-chair with pillows to each side of the body.

Observation of the resident on May 14, 2012, at 9:45 a.m., revealed the resident in the room in a reclined geri-chair. Resident was anxious and confused, and was unable to exit the chair independently.

Interview with the DON, at the time of the observation, confirmed the recliner is a restraint if the chair prevents the resident from rising independently. The DON further confirmed the facility's restraint policy had not been followed, the comprehensive assessment was inaccurate, there was no physician's order, consent, or pre-restraint assessment related to the geri-chair. Continued interview revealed no restraint assessments or restraint reduction attempts were documented since 2010.

Resident #19 was admitted to the facility on October 22, 2010, with diagnoses including Diabetes Mellitus type 2, Chronic Catatonia, Dehydration, and Venous Thrombosis.

Medical record review of the Minimum Data Set (MDS), dated March 3, 2012, revealed the resident was moderately impaired cognition and required extensive assistance with activities of daily living, toileting and bathing.

Medical record review of the Care Plan, dated January 8, 2012, revealed "...side rails up on both

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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{F 221}	Continued From page 18 sides while resident is in bed..." Medical record review on May 14, 2012, at 11:30 a.m., revealed no pre-restraint assessment, no side rail assessment or Physician's Order for the use of the side rails. Observation on May 14, 2012, at 10:00 a.m., in the resident's room, revealed the resident lying in the bed with the use of two full side rails. Interview with the Director of Nursing (DON), on May 15, 2012, at 8:15 a.m., in the DON office, confirmed the facility did not perform a pre-restraint assessment or side rail assessment, and two side rails were in use when the resident was in the bed and the facility did not obtain a Physcian's Order for the side rails. Resident # 26 was admitted to the facility on July 28, 2003, with diagnoses of Essential Hypertension, Macular Degeneration, Cerebral Vascular Accident, Senile Dementia, Chronic Kidney Disease, and Osteoarthritis. Medical record review of the MDS, dated April 26, 2012, revealed the resident had moderate impairment of cognitive skills and highly impaired vision. Medical record review of the Care Plan, dated January 26, 2012, revealed "...bilateral side rails X (times) 2..." Observation on May 15, 2012, at 1:35 p.m., in the resident's room, revealed the resident lying in the bed with both side rails up and in use.	{F 221}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 221}	Continued From page 19 Interview with the Director of Nursing (DON), on May 15, 2012, at 2:15 p.m., in the DON office, confirmed the facility did not perform a side rail assessment, two side rails were in use when the resident was in the bed and the facility failed to obtain a physician's order for the side rails. Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the MDS dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment and restraints were not used. Medical record review of the Care Plan dated March 15, 2012, revealed "...SR (side rails) up times 2 to prevent...falling OOB (out of bed)..." Medical record review of the Resident Plan of Care Instructions, no date, revealed "...restraint 2 bed rails..." Medical record review revealed no signed consent for use of the restraints, and no pre-restraint or side rail assessment. Further medical record review revealed no Physician Order for the use of the side rails. Review of the facility policy, "Restraint Use", revealed "...If evaluation shows the need for physical restraint the physician will be notified for direction/order...with use of any restraint the resident must be observed q (every) 30 minutes and position changed (at) least q 2 hours...Before	{F 221}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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{F 221}	Continued From page 20	{F 221}		

any restraint orders are obtained, the following steps must be completed and the need deemed necessary. A restraint assessment, including alternatives must be completed..."

Observation on May 15, 2012, at 8:00 a.m., in the resident's room, revealed the resident lying on the bed with the full side rails on the bed and the bed rails in the up position bilaterally.

Interview with the Director of Nursing (DON) on May 14, 2012, at 11:30 a.m., in the DON office, confirmed no pre-restraint assessment or side rail assessment had been completed and no Physician Order for side rail restraint.

Resident #12 was admitted to the facility on March 29, 2012, with diagnoses including Contusion to Knee, Diabetes Mellitus, and Fibromyalgia.

Medical record review of the MDS dated March 29, 2012, revealed the resident scored a twelve of fifteen on the BIMS with moderately impaired cognitive skills and bed rail restraints were used daily.

Medical record review of the Care Plan last reviewed on April 4, 2012, revealed "...at risk for falls...side rails up x (times) 2...remind resident not to stand without assist..."

Observation on May 9, 2012, at 8:00 a.m., in the resident's room, revealed the resident lying on the bed with the full side rails on the bed and the bed rails in the up position bilaterally.

Interview with the DON on May 14, 2012, at 11:30

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 221}	Continued From page 21 a.m., in the DON office confirmed no pre-restraint assessment or side rail assessment had been completed and no Physician Order for the side rail restraint. Resident #16 was admitted to the facility on December 20, 1994, with diagnoses including Cerebral Palsy, Seizure Disorder, and Encephalopathy. Medical record review of the MDS dated March 15, 2012, revealed the resident was moderately impaired for decision making, is totally dependent for all activities of daily living, and physical restraints (bed rail and trunk restraint) used daily. Medical record review of the Care Plan noted as last reviewed on June 16, 2011, revealed "...restraints...low bed with padded rails...SR x (times) 2 when in bed..." Observation on May 9, 2012, at 9:30 a.m., in the resident's room, revealed the resident lying on the bed with the full side rails on the bed and the bed rails in the up position bilaterally. Observation on May 15, 2012, at 11:30 a.m., in the activity room, revealed the resident sitting in a wheelchair with the shoulder straps in place. Interview with the DON on May 14, 2012, at 11:30 a.m., in the DON office, confirmed no pre-restraint or quarterly restraint assessments had been completed. Resident #18 was admitted to the facility on March 1, 2006, with diagnoses including Senile	{F 221}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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{F 221}	Continued From page 22 Dementia, Osteoarthritis, Osteoporosis, Psychosis, Hypothyroidism, and Depressive Disorder. Medical record review of the MDS dated March 1, 2012, revealed the resident had short and long term memory problems, required extensive assistance with ambulation and activities of daily living, and used restraints daily. Medical record review of a Care Plan last reviewed on March 1, 2012, revealed "...side rails up times 2..." Medical record review revealed the resident had no signed consent for the use of the restraints and no pre-restraint assessment and no side rail assessment. Further medical record review revealed no Physician Order for the use of side rails. Medical record review of a Nurse's Progress Note dated August 10, 2011, revealed "...resident crawled between foot board and bed rail...observed on floor..." Observations on May 14, 2012, at 1:00 p.m. and May 15, 2012, at 2:11 p.m., in the resident's room, revealed the resident lying in bed with full side rails on the bed and in the up position bilaterally.	{F 221}		
{F 223} SS=E	C/O #27265 #28092 #27636 #27230 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal	{F 223}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 221}	Continued From page 22 Dementia, Osteoarthritis, Osteoporosis, Psychosis, Hypothyroidism, and Depressive Disorder. Medical record review of the MDS dated March 1, 2012, revealed the resident had short and long term memory problems, required extensive assistance with ambulation and activities of daily living, and used restraints daily. Medical record review of a Care Plan last reviewed on March 1, 2012, revealed "...side rails up times 2..." Medical record review revealed the resident had no signed consent for the use of the restraints and no pre-restraint assessment and no side rail assessment. Further medical record review revealed no Physician Order for the use of side rails. Medical record review of a Nurse's Progress Note dated August 10, 2011, revealed "...resident crawled between foot board and bed rail...observed on floor..." Observations on May 14, 2012, at 1:00 p.m. and May 15, 2012, at 2:11 p.m., in the resident's room, revealed the resident lying in bed with full side rails on the bed and in the up position bilaterally.	{F 221}		
{F 223} SS=E	C/O #27265 #28092 #27636 #27230 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal	{F 223}	F223 483.13(b), 483.13 (c) (l) (i) Free From Abuse / Involuntary Seclusion	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{F 223}	Continued From page 23 punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of staff written statements, review of facility policy, observation, and interview, the facility failed to protect four (#1, #2, #3, #11) residents from abuse of twenty-seven residents reviewed. The facility's failure to protect the residents from abuse placed resident #1, #2, in Immediate Jeopardy. (Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation, has caused or is likely to cause, serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on May 30, 2012. A revisit conducted on June 4 - June 5, 2012, revealed the corrective actions implemented on May 30, 2012, removed the Immediate Jeopardy. Non-compliance for F-223 continues at an "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with residents and facility staff, including administrative staff.	{F 223}	1) After being informed of the facility's failure to protect residents from abuse the following was put in place: Resident #1 - Changed resident's Care Plan effective 05/16/2012: 1. Deleted the approaches for his disruptive behavior that allowed resident to be placed in room with door closed with wheelchair disengaged, power cord removed from chair 2. Changed resident's 10:30 p.m. bedtime to allow him to determine his own bed time. All residents are permitted to go to bed at their choice of time effective 05/16/2012 by MDS Coordinator. Exhibit # 1 On 05/16/2012 the changes to resident # 1's Care Plan was verbally communicated to the nursing staff working on the 6 a.m. – 2 p.m., 2 – 10 p.m., and 10 p.m. – 6 a.m. shifts by the DON & MDS Coordinator and all subsequent shifts until the written revised care plan was completed later on that day, 05/16/2012.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 223}	Continued From page 24 The facility provided evidence Resident #1's care plan was revised to eliminate involuntary seclusion and eliminate the 10:30 p.m., bedtime. The facility provided evidence of care plan reviews to ensure appropriate behavioral interventions and Residents were allowed to determine their own bedtime. The facility provided evidence Residents were assessed for signs of abuse, complaints of abuse, and behavioral needs. The Medical Director evaluated all Residents with psychoactive medications and Residents with behavioral diagnoses. The facility provided evidence the Geriopsych provider consulted with Residents with a history of impaired cognition, behavioral episodes, and/or mental illness. Licensed Practical Nurse #3 resigned before the Director of Nursing implemented an individual counseling. The Director of Nursing did report Licensed Practical Nurse #3 to the Board of Nursing. The facility provided evidence of in-services related to policies and procedures for Abuse (to include reporting and investigating abuse immediately); Resident Rights; Safety (to include Accidents and Supervision); Fall Investigation; Care of the Resident with Seizures; Restraint Management; Behavior Assessment and Monitoring Program; and Social Services Assessment and History.	{F 223}	On 05/16/2012, the Administrator conducted a late investigation regarding resident # 1's allegation that employee's husband blocked him in his room and touched his arm. -5/27/12-Inservice given by Administrator to employees' spouse. -Witness statement was added to the abuse investigation form. A one on one in-service was given to the employee's spouse by the Administrator on 5/17/12. -Employee's spouse attended an in-service on abuse and neglect on 5/27/12. -On 5/29/12, the DON investigated an allegation of abuse, using the new forms approved on 5/27/12, including witness statements and documented interviews. Exhibit # 35 On 05/16/2012 the Administrator conducted a late investigation regarding resident #1's allegation of an employee's spouse making threatening remarks to him.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 223	Employee no longer employed. Late investigation revised and a witness statement added. Exhibit #3-revised On 5/27/12, DON completed an allegation of abuse utilizing the new process for complaint investigations which included verbal and written employee and resident statements. Exhibit #35 On 05/19/2012, the Administrator conducted an investigation regarding the housekeeping supervisor's comment about resident # 1 looking in a mirror and seeing a monkey. Corrective action was noted on the investigation. One on one in-service to Housekeeping Supervisor 5/19/2012 by the Administrator. Exhibit # 4 The Abuse Investigation Policy & Restraint Management Policy was reviewed and revised by the DON and Health Care Consultant on 05/28/2012 and these policies were	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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		F 223	reviewed by the Health Care consultant with the DON, Administrator and Medical Director emphasizing the elimination of the use of seclusion, reporting abuse, investigation of abuse, and of using the Resident Abuse Investigation Report Form. Inservices conducted on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until in-services are complete. DON/RN will oversee in-services and report to QA/PI. Exhibit # 5 <u>Resident # 2 & # 3</u> Resident #3 was discharged 12/14/10. The DON implemented a Behavior Assessment and Monitoring program effective following approval by the Medical Director on	

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		F 223	05/27/2012 and the QA committee on 05/27/2012. All residents admitted with a history of impaired cognition problematic behavior, or mental illness will have a consultation with a Geriopsych practitioner. This was addressed in the revised Behavior Assessment & Monitoring policy. This policy was reviewed & approved by the Medical Director and QA committee on 05/27/2012. Inservices conducted on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 6 All residents admitted to the facility will have a Social Services Assessment / History according to facility policy. Administrator reviewed with the Social Services Coordinator on 05/17/2012. A one	

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		F 223	on one inservice was conducted with current Social Service Coordinator on 5/17/12 by the administrator. Exhibit # 7 <u>Resident # 11</u> On 05/16/12 the DON began the process for counseling LPN #3 concerning her approach to Resident #11 for inappropriate nursing actions related to cleaning up feces from floor. Employee resigned May 17, 2012 before actual counseling was done. This incident was reported to the Board of Nursing by DON on 05/29/2012. Exhibit # 8 **2)** The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on –Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 223	Management. Inservices were given 5/27/1-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. The following policies or procedures have been changed to address this deficiency practice: -Use of Restraints -Behavior Assessment and Monitoring -Side rail Evaluation on Admission and Quarterly -Abuse Investigation - Resident Rights Guidelines for all nursing procedures Inservices conducted to RN, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 223	until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 10 Teachable moments/in-services were conducted by DON on 5/24 and 5/25/12 -Resident Rights and Dignity -Restraints i.e.: Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management Inservices conducted on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 11 On 5/27/12 The Medical Director evaluated and assessed all residents with psychoactive medications or residents with behavior diagnoses.	

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		F 223	The evaluation was also documented in the Medical Record on 5/27/12. ADON/DON/MDS Coordinator assessed all other residents for signs of abuse, complaints of abuse, and any behaviors needing a consultation of the physician or Geriopsych Consultant. This assessment began on 5/15/2012, completed on 5/27/12. All residents care plans were reviewed by MDS Coordinator for appropriate behavior interventions. This process began on 5/15/2012, completed on 5/29/12. **3)** The DON or designee will monitor all behaviors weekly to ensure residents care is managed appropriately. A weekly behavior template was added to Electronic Medical Record System to capture Behavior assessment for each resident on 6/1/12. Exhibit # 68	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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		F 223	A list of residents will be provided to DON on each visit from Geriopysch Services. Resident #1 goes to mental health monthly. Restraints will be monitored weekly for four weeks until process is in place and functioning efficiently, then quarterly thereafter. Abuse allegations will be monitored and logged as received, effective 5/15/2012. The DON/ MDS Coordinator/ PT will monitor all falls. The DON/designee will monitor all restraints assessed and ordered by physician to ensure that all residents are safe by utilizing the least restrictive measures possible. This will be monitored for three months and reevaluated at that time if monitoring needs to continue with approval from the QAPI Committee. The DON/designee will monitor all residents to ensure the absence of all forms of abuse, including involuntary seclusion. This was begun on 5/29/12 and will continue	

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{F 223}	Continued From page 25 Observation of the Residents throughout the follow-up visit revealed no Residents were involuntarily secluded; and there were no observations of Resident altercations. Facility staff provided diversion activities to behavioral and wandering Residents. The facility environment was calm with planned activities taking place. Interviews with Resident #1 and a random Resident confirmed they have not been involuntarily secluded and can go to bed at the time of their choice. Interviews with random facility staff during the revisit confirmed they had received in-services related to Abuse, Restraint Management, and Behavioral Management; and how to report and investigate allegations of Resident abuse; and how to care for the Resident who displayed aggressive or inappropriate behaviors and to report these behavioral incidents. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	weekly indefinitely to ensure all abuse has been investigated. 4) The DON will report the outcomes of abuse, behavior management, and restraint monitoring to the quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is scheduled 6/20/12.	
{F 226} SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	{F 226}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 223}	Continued From page 25 Observation of the Residents throughout the follow-up visit revealed no Residents were involuntarily secluded; and there were no observations of Resident altercations. Facility staff provided diversion activities to behavioral and wandering Residents. The facility environment was calm with planned activities taking place. Interviews with Resident #1 and a random Resident confirmed they have not been involuntarily secluded and can go to bed at the time of their choice. Interviews with random facility staff during the revisit confirmed they had received in-services related to Abuse, Restraint Management, and Behavioral Management; and how to report and investigate allegations of Resident abuse; and how to care for the Resident who displayed aggressive or inappropriate behaviors and to report these behavioral incidents. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}		
{F 226} SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	{F 226}	**F226 483.13(c) Develop/ Implement Abuse/Neglect, etc. Policies.** 1) Resident # 1	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{F 226}	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, review of personnel files, observation, and interview, the facility failed to thoroughly investigate allegations of abuse for three (#1, #16, #11) residents of twenty-seven residents reviewed, failed to check the abuse registry for six of six personnel files reviewed, and failed to in-service direct care staff on abuse in 2011 and no abuse in-services currently in 2012. The facility's failure to thoroughly investigate allegations of abuse placed residents #1, #16, #11 in Immediate Jeopardy. (Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on May 30, 2012. A revisit conducted on June 4 - June 5, 2012, revealed the corrective actions implemented on May 30, 2012, removed the Immediate Jeopardy. Non-compliance for F-226 continues at an "F" level (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff, including administrative staff. The facility provided evidence the Abuse Investigation Policies and Procedures were	{F 226}	On 5/16/12 the Administrator conducted a late investigation on the allegation made by resident # 1 that the employee's spouse blocked him in room, touched his arm, and threatened him. -5/27/12-Inservice given by Administrator to employees' spouse. -Witness statement was added to the abuse investigation form. A one on one in-service was given to the employee's spouse by the Administrator on 5/17/12. -Employee's spouse attended an in-service on abuse and neglect on 5/27/12. -On 5/29/12, the DON investigated an allegation of abuse, using the new forms approved on 5/27/12, including witness statements and documented interviews. Exhibit # 2 Exhibit #35 On 05/16/2012 the Administrator conducted an investigation regarding resident #1's allegation of an employee's spouse making threatening remarks to him.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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(F 226)	Continued From page 27 revised, to include an improved incident reporting process to capture abuse incidents, for improved tracking of abuse, and to ensure investigation. The facility provided evidence allegations of abuse were investigated according to the revised Abuse Investigation Policy and Procedure. Licensed Practical Nurse #3 resigned before the Director of Nursing implemented an individual counseling. The Director of Nursing did report Licensed Practical Nurse #3 to the Board of Nursing. The facility provided evidence of completed Abuse Registry Checks on all currently employed facility staff. The facility is using a new process to conduct background checks, to include abuse registry checks, which is being completed by the facility's Office Manager. The facility provided evidence each employee's attendance for mandatory in-services, conducted twice each year, are being documented and tracked. The facility provided evidence of care plan reviews to ensure appropriate behavioral interventions and Residents were allowed to determine their own bedtime. The facility provided evidence Residents were assessed for signs of abuse, complaints of abuse, and behavioral needs. The Medical Director evaluated all Residents with psychoactive medications and Residents with behavioral diagnoses; and the Geriopsych	(F 226)	-Witness statement was obtained and added to the exhibit. Exhibit #3-revised 5/27/12-Inservice given by Administrator to employees' spouse. Exhibit #2 On 5/16/12, the Administrator conducted a late investigation regarding resident #1 allegation that another employee's spouse was making threatening remarks to him. Employee no longer employed. Late investigation revised and a witness statement added. Exhibit # 3-revised Reported to staff allegations of another resident having grabbed him on July 7, 2011. This was investigated by previous DON and noted in resident's medical record on July 7, 2011. Attached are the progress notes of the investigation Exhibit # 12	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 226	Resident #16 On 2/19/12, MDS Coordinator entered a note in medical records noting inappropriate feeding by family member. MDS Coordinator intervened and replaced family member who was feeding resident inappropriately at the time of noted occurrence. Exhibit # 13 Abuse investigation policies have been reviewed and revised on 5/27/2012 by the DON, and approved by Medical Director, Administrator, and QA Committee 5/27/12. On 5/27/12, DON revised Incident reporting process to capture abuse incidents on the facility's Incident Report form to improve tracking and ensure investigation. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete.	

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		F 226	DON/RN will oversee inservices and report to QA/PI. Exhibit # 5 Resident # 11 On 05/16/12 the DON began the process for counseling LPN #3 concerning her approach to Resident #11 for inappropriate nursing actions related to cleaning up feces from floor. Employee resigned May 17, 2012 before actual counseling was done. This incident was reported to the Board of Nursing by DON on 05/29/2012. Exhibit # 8 Abuse investigation policies have been reviewed and revised on 5/27/2012 by the DON, and approved by Medical Director, Administrator, and QA Committee 5/27/12. On 5/27/12, DON revised Incident reporting process to capture abuse incidents on the facility's Incident Report form to improve tracking and ensure investigation. Inservices	

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		F 226	given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit #5 Upon notification that there were six employees with no abuse checks conducted, on 5/16/12, the Office Manager began obtaining abuse registry checks which were completed on 5/28/12. The documentation and tracking of employee attendance at mandatory in-services i.e. abuse attendance and other in-services were evaluated by the DON and a new process was implemented on 5/29/12. Each employee will have an attendance record with the mandatory in-services typed on the attendance record form with attendance date to be recorded when in-service is attended. The DON will conduct	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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		F 226	mandatory in-services at least twice a year to ensure an opportunity for employee attendance. DON/Office Manager will oversee inservices and report to QA/PI. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will not be able to work until inservices are complete. Exhibit # 16 **2)** The DON reviewed the deficiencies stated in the 2567 to. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on –Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior Management. In-services were given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-	

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		F 226	5/30/12. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 15 Exhibit #9 The following policies or procedures have been changed to address these deficient practices: -Use of Restraints -Behavior Assessment and Monitoring -Side rail Assessment on Admission and Quarterly -Abuse Investigation -Resident Rights – Guidelines for all Nursing Procedures All in-services given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will not be able to work until in-services are complete. DON/RN will oversee inservices and report to QA/PI.	

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		F 226	Exhibit #10 Teachable moments/in-services for licensed staff were conducted by DON on 5/24 and 5/25/12 on the following topics: -Resident Rights and Dignity -Restraints i.e. Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit #11 On 5/27/12, the Medical Director evaluated and assessed all resident with psychoactive medication and/or residents with behavior diagnoses. The evaluation was documented in the resident's Medical Record on 05/27/12.	

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		F 226	All resident's care plans were reviewed and revised for appropriate approaches/ interventions for abuse and seclusion and resident rights by the MDS Coordinator. This process was begun 5/16/12 and completed on 5/29/12. All other residents were assessed for S/S of abuse by MDS Coordinator/ DON/ADON, completed 5/29/2012. On 5/29/11 the Administrator changed the company conducting background checks to a new instant National Criminal Background Check-Sentrylink. The changes were made to expedite receiving results of requested background check and National Sex offenders' registry. On 5/27 and 5/28 all employees files were checked for abuse, and other required checks by the Office Manager. 3) On 5/27/12, DON has developed a log to ensure capturing of all abuse complaints for timely investigation. . A new form for	

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{F 226}	Continued From page 28 provider consulted with Residents with a history of impaired cognition, behavioral episodes, and/or mental illness. The facility provided evidence of in-services related to policies and procedures for Abuse (to include reporting and investigating abuse immediately); Resident Rights; Safety (to include Accidents and Supervision); Fall Investigation; Care of the Resident with Seizures; Restraint Management; Behavior Assessment and Monitoring Program; and Social Services Assessment and History. The employee's spouses were in-serviced by the facility's Administrator. Observation of the Residents throughout the follow-up visit revealed facility staff interacted appropriately with the Residents, according to facility Abuse Policies and Procedures. Interviews with random facility staff during the revisit confirmed they had received in-services related to Abuse, Restraint Management, and Behavioral Management; and how to report and investigate allegations of Resident abuse; and how to care for the Resident who displayed aggressive or inappropriate behaviors and to report these behavioral incidents. The facility will remain out of compliance at an "F" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	conducting abuse investigations was approved for use to capture all required information. The Office Manager will maintain a list of employees with date of abuse registry checks. No employee will be able to begin work until registry checks are complete. This will be monitored by the Administrator monthly. 4) The DON will report the outcomes of abuse investigations, abuse registry checks to the quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is scheduled 6/20/12.	
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	{F 241}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 226}	Continued From page 28 provider consulted with Residents with a history of impaired cognition, behavioral episodes, and/or mental illness. The facility provided evidence of in-services related to policies and procedures for Abuse (to include reporting and investigating abuse immediately); Resident Rights; Safety (to include Accidents and Supervision); Fall Investigation; Care of the Resident with Seizures; Restraint Management; Behavior Assessment and Monitoring Program; and Social Services Assessment and History. The employee's spouses were in-serviced by the facility's Administrator. Observation of the Residents throughout the follow-up visit revealed facility staff interacted appropriately with the Residents, according to facility Abuse Policies and Procedures. Interviews with random facility staff during the revisit confirmed they had received in-services related to Abuse, Restraint Management, and Behavioral Management; and how to report and investigate allegations of Resident abuse; and how to care for the Resident who displayed aggressive or inappropriate behaviors and to report these behavioral incidents. The facility will remain out of compliance at an "F" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}		
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	{F 241}	F 241 483.15(a) Dignity and Respect of Individuality	6/6/12

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{F 241}	Continued From page 29 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to promote care that maintained or enhanced dignity during a meal time for two residents (#16 and #23) of twenty-seven residents reviewed. The findings included: Resident #16 was admitted to the facility on December 20, 1994, with diagnoses including Cerebral Palsy, Seizure Disorder, and Encephalopathy. Medical record review of the MDS dated March 15, 2012, revealed the resident was moderately impaired for decision making and was totally dependent for all activities of daily living and eating. Observation on May 15, 2012, at 8:00 a.m., in the activity room, revealed the resident in the activity room, sitting in the wheelchair being fed breakfast by Certified Nurse Aide (CNA) #16. Observation on May 15, 2012, at 8:10 a.m., in the activity room, revealed CNA #16 standing in front of Resident #16 feeding the resident. Resident #23 was admitted to the facility with	{F 241}	**Resident # 16 & # 23** 1) Upon being made aware of CNA #16 deficient practice of feeding Resident #16 & #23, the DON in-serviced her on the proper way to feed residents on 5/15/12. The DON or designee conducted an in-service with all RNs, LPNs and CNAs on the proper way to feed residents – not standing and free from interference from other residents/ policy "Quality of Life – Dignity" on 5/24/12 & 5/28/12. Any RN, LPN & CNA who have not attended the above in-service cannot work until they have attended an in-service on feeding residents. Exhibit #69 2) On 5/15/12 to 5/29/12 all other residents who required assistance with feeding were observed by DON or designee for use of proper feeding technique. This policy will be in-serviced quarterly for the next 6 months beginning with 6/1/12 to all RNs, LPNs and CNAs. Exhibit #70	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 241}	Continued From page 30 diagnoses including Dementia, and Osteoporosis. Medical record review of the MDS dated March 15, 2012, revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and was on a mechanically altered diet. Observation on May 15, 2012, at 8:05 a.m., in the activity room, revealed Resident #23 sitting in a wheel chair, CNA #16 standing in front of Resident #23 feeding the resident with a sixty cc (cubic centimeters) syringe and Resident #16 poking Resident #23 in the head with finger. Interview with the Director of Nursing (DON) in the activity room, confirmed the facility failed to maintain or enhance dignity during dining for two Residents #16 and #23, the activity room was small and the staff must stand to feed the residents.	{F 241}	3) The DON or designee will monitor for any violations of Resident's dignity during meal time. The policy "Quality of Life - Dignity" will be in-serviced quarterly for the next 6 months beginning June 1, 2012. The DON will ensure this policy is a part of orientation of new employees beginning 6/1/12. The DON or designee will monitor residents randomly for any violations of Resident's dignity. This was begun on 6/1/12 and will continue monthly for 3 months then as needed to ensure compliance has been achieved. 4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI meeting is scheduled for 6/20/12.	
{F 242} SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	{F 242}		

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{F 241}	Continued From page 30 diagnoses including Dementia, and Osteoporosis. Medical record review of the MDS dated March 15, 2012, revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and was on a mechanically altered diet. Observation on May 15, 2012, at 8:05 a.m., in the activity room, revealed Resident #23 sitting in a wheel chair, CNA #16 standing in front of Resident #23 feeding the resident with a sixty cc (cubic centimeters) syringe and Resident #16 poking Resident #23 in the head with finger. Interview with the Director of Nursing (DON) in the activity room, confirmed the facility failed to maintain or enhance dignity during dining for two Residents #16 and #23, the activity room was small and the staff must stand to feed the residents.	{F 241}		
{F 242} SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	{F 242}	**F242 483.15(b) Self-Determination – Right to Make Choices** **Resident #1** 1) The MDS Coordinator changed Resident #1's care plan from a set bed time of 10:30 to allow resident a choice of bed time. This was done on 5/16/12. The MDS Coordinator reviewed the revised care plan with	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 242}	Continued From page 31 and interview, the facility failed to allow one resident (#1) to make choices of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills and no memory impairment. Medical record review of the Care Plan dated March 15, 2012, revealed "...to go to bed at 11:30 pm...allow to make choices...not allowed to curse outside of room..." Medical record review of a Behavior Note dated October 19, 2011, at 10:45 p.m., revealed "...instructed resident of care plan that states needs to go to bed when 3rd shift (10 p.m. - 6:00 a.m.) first gets here...said no didn't have to...restated we need to follow care plan..." Medical record review of a Nurse's Note dated October 20, 2011, at 12:00 p.m., revealed "...W/C (wheelchair) still disengaged (remove battery)...C/O (complains of) not being taken care of...did want to lay down which according to care plan is on third shift...been primarily sleeping in chair all morning..." Medical record review of a Behavior Note dated	{F 242}	Resident on 5/16/12 and then communicated the care plan changes by memo and verbally to all RNs, LPNs & CNAs. Any RNs & LPNs who have not acknowledged reading the above memo cannot work until they have signed the in-service sheet stating they have read the memo. 2) On 5/15/12 all other residents' care plans were reviewed by the MDS Coordinator for any set times for bed time. No other residents had set times for bed. The policy "Quality of Life - Dignity" was provided to each RN & LPN on 6/1/12 to reinforce the in-service conducted on 5/29/12. Exhibit #71 3) The MDS Coordinator will monitor all care plans for appropriate interventions beginning 5/29/12. This policy "Quality of Life - Dignity" will be in-serviced quarterly for the next six months then as needed to ensure compliance has been achieved. This policy will be part of orientation for new employees beginning 6/1/12.	

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{F 242}	Continued From page 32 March 2, 2012, at 11:30 p.m., revealed "...asked resident if...wanted to go to bed...told to get out of...room...per...care plan...needed to go to bed..." Observation and interview with the resident on May 7, 2012, at 10:45 a.m., in the resident's room, revealed the resident sitting in a motorized wheelchair. Interview at this time revealed the facility had given the resident a bedtime of 10:30 p.m., and the resident does not want to go to bed at 10:30 p.m. Interview with the Director of Nursing (DON) on May 8, 2012, at 2:30 p.m., in the front office, confirmed the facility had given the resident a bedtime (when 3rd shift arrives), it is care planned, and the staff had been instructed to follow the care plan. Continued interview at this time confirmed if the resident refuses to go to bed when 3rd shift arrives, the resident must wait until the staff complete the first round (checking all residents) and the resident does not have a choice when the resident goes to bed. Interview with the DON on May 14, 2012, at 8:45 a.m., in the DON office, revealed the resident requested to go to bed on October 20, 2012, at 12 noon, the resident was informed according to the Care Plan bedtime was on third shift and the facility failed to allow the resident a choice of when to go to bed.	{F 242}	4) The MDS Coordinator will monitor care plan updates for correct and appropriate interventions quarterly. This was begun on 5/29/12 and will continue monthly for 6 months then as needed to ensure compliance has been achieved. The MDS Coordinator will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
{F 250} SS=D	C/O #27265 #28092 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	{F 250}		

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{F 242}	Continued From page 32 March 2, 2012, at 11:30 p.m., revealed "...asked resident if...wanted to go to bed...told to get out of...room...per...care plan...needed to go to bed..." Observation and interview with the resident on May 7, 2012, at 10:45 a.m., in the resident's room, revealed the resident sitting in a motorized wheelchair. Interview at this time revealed the facility had given the resident a bedtime of 10:30 p.m., and the resident does not want to go to bed at 10:30 p.m. Interview with the Director of Nursing (DON) on May 8, 2012, at 2:30 p.m., in the front office, confirmed the facility had given the resident a bedtime (when 3rd shift arrives), it is care planned, and the staff had been instructed to follow the care plan. Continued interview at this time confirmed if the resident refuses to go to bed when 3rd shift arrives, the resident must wait until the staff complete the first round (checking all residents) and the resident does not have a choice when the resident goes to bed. Interview with the DON on May 14, 2012, at 8:45 a.m., in the DON office, revealed the resident requested to go to bed on October 20, 2012, at 12 noon, the resident was informed according to the Care Plan bedtime was on third shift and the facility failed to allow the resident a choice of when to go to bed.	{F 242}		
{F 250} SS=D	C/O #27265 #28092 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	{F 250}	**F250 483.15(g)(i) Provision of Medically Related Social Service**	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

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{F 250}	Continued From page 33 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide social services adequate to meet the needs of one (#1)resident of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, Depression, Anxiety, and Bipolar Disorder. Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment verbal behavioral symptoms directed toward others occurred four to six days per week (less than daily), and rejection of care occurred four to six days per week (less than daily). Continued review of the MDS revealed the resident required total staff assistance for transfers, and activities of daily living. Medical record review of an Interdisciplinary Care Plan, dated March 15, 2012, revealed "...problem: behavior...inappropriate/disruptive behavior...displays persistent anger with staff...easily annoyed..."	{F 250}	1) Upon being made aware that Resident #1 did not have quarterly Social Services assessment, the Administrator reviewed the 2567 with the Social Services Coordinator. The Social Service Coordinator completed the quarterly assessment on Resident #1 on 5/21/12. On 5/17/12, the Administrator in-serviced the Social Service Coordinator on the regulatory requirements for admission, significant changes, and quarterly notes needed for each resident. 2) On 5/15/12 to 5/29/12 all other residents were review for need of quarterly assessment by the Social Service Coordinator. No other residents were identified as needing a quarterly note. 3) The Social Service Coordinator will monitor for delinquent quarterly notes on a monthly basis. A log will be maintained of residents with dates of next assessment due. The Social Service Coordinator will provide a copy of log to administrator on a quarterly basis beginning 6/1/12.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 250}	Continued From page 34 Medical record review revealed no Social Services Progress Notes from September 2011 to May 16, 2012. Medical record review of a Nurse's Note dated September 20, 2011, at 5:25 a.m., revealed "...Pt (patient) upset started cussing..." Medical record review of a Nurse's Note dated October 20, 2011, at 12:15 a.m., revealed "yelling and cursing from room..." Medical record review of a Nurse's Note dated March 6, 2012, at 8:04 p.m., revealed "...continues to curse...unable to have CNA's help...at this time due to...behaviors..." Interview with the Director of Nursing on May 16, 2012, at 8:40 a.m., in the front office, revealed Resident #1 was known to curse, place demands on the staff, and this frequently upset other residents. Interview continued and confirmed a behavior management program had not been established for the resident. Telephone interview with the Nurse Practitioner #1 on May 15, 2012, at 3:12 p.m., confirmed Resident #1 was diagnosed with Depression, Mood Disorder, Anxiety, and Bipolar Disorder. Continued interview confirmed the resident had frequent episodes of cursing the staff and no formal behavior management program had been established for the resident by the Interdisciplinary Team including nursing, Psychiatric Services and Social Services. Interview with the Social Service Director on May	{F 250}	The Administrator will monitor residents randomly for Social Services notes. This was begun on 6/1/12 and will continue monthly for 3 months, then as needed to ensure compliance has been achieved. 4) The Social Service Coordinator will report the outcomes of completed assessments to the quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is scheduled 6/20/12.	

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{F 250}	Continued From page 35 14, 2012, at 3:30 p.m., in the physical therapy office, confirmed had been aware of the resident's behaviors; aware of intervention of seclusion for behaviors; had never addressed the residents behaviors; the resident attends Community Mental Health Center off the campus; and the Social Service Director had no contact with the mental health center.	{F 250}		
{F 278} SS=E	C/O #27265 #28092 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	{F 278}	**F 278 483.20 (g)-(j) Assessment Accuracy/ Coordination/ Certified** **Resident #1, #13, #16, #2, #4, & #14** **1)** The MDS Coordinator changed the above Resident's MDS and Care Plan to reflect current status. This was done on 5/16/12 – 5/29/12. The MDS Coordinator corrected the MDS Assessments on the above residents on 5/15/12 to 5/29/12 and modified their care plan accordingly. On 5/29/12 the MDS Coordinator then communicated the care plan changes by memo to all RNs, LPNs & CNAs giving Residents an opportunity to change their plan of care. Any RNs, LPNs, & CNAs who have not acknowledged reading the above	6/6/12

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{F 278}	Continued From page 36 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure accuracy of the Minimum Data Set (MDS) for six residents (#1, #13, #16, #2, #4, and #14) and failed to complete a feeding assessment for two residents (#23, and #24) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the MDS dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills, no memory impairment and restraints were not used. Continued review of the MDS revealed no diagnosis for seizure disorder for Resident #1. Medical record review of the Care Plan dated March 15, 2012, revealed "...SR (side rails) up times 2 to prevent...falling OOB (out of bed)..." Medical record review of Resident Plan of Care Instructions no date revealed "...restraint 2 bed rails..." Medical record review of Physician Recapitulation	{F 278}	memo cannot work until they have signed the in-service sheet stating they have read the memo. Exhibit #72, 73 2) On 5/15/12 all other residents' MDS Assessments and care plans were reviewed by the MDS Coordinator for needed changes. No other residents needed changes. On 5/29/12 the MDS Coordinator then communicated the care plan changes by memo to all RNs, LPNs & CNAs giving Residents an opportunity to change their plan of care. Any RNs & LPNs who have not acknowledged reading the above memo cannot work until they have signed the in-service sheet stating they have read the memo. 3) The MDS Coordinator will monitor all MDS Assessments and care plans for appropriate data and interventions beginning 5/29/12. A trending report was developed for reporting to the QAPI Committee. The MDS Coordinator will monitor MDS Assessments and care plans for correct and appropriate data and interventions quarterly. This was	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 278}	Continued From page 37 Orders dated May 2012, revealed "...DX: (diagnoses) Seizure Disorder..." Observation on May 8, 2012, at 8:00 a.m., in the resident's room, revealed the resident asleep, lying on the bed, the side rails up times two, and the call light in place. Resident #13 was admitted to the facility on November 5, 2009, with diagnoses including Seizure Disorder, Chronic Pain, and Congestive Heart Failure. Medical record review of the MDS dated February 23, 2012, revealed the resident had long term memory problem, and required supervision for activities of daily living. Continued MDS review revealed no diagnosis for Seizure Disorder for Resident #13. Medical record review of the Care Plan dated February 23, 2012, revealed "...seizures...resident will remain free of injury..." Medical record review of Physician Recapitulation Orders dated May 2012, revealed "...DX: (diagnoses) Seizure Disorder..." Resident #16 was admitted to the facility on December 20, 1994, with diagnoses including Cerebral Palsy, Seizure Disorder, and Encephalopathy. Medical record review of the MDS dated March 15, 2012, revealed no diagnosis for Seizure Disorder. Medical record of the Care Plan dated last review	{F 278}	begun on 5/29/12 and will continue quarterly. 4) The MDS Coordinator will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12. **Resident #23 & #24** 1) Residents #23 & #24 were assessed on 5/17/12 by the DON for need of use of a syringe for eating. On 5/17/12 the DON notified the MD and family/POA of the discontinuing the use of syringe for feeding. CNA #16 and CNA Student #1 was in-serviced by the DON on 5/14/12 concerning their practice of feeding Resident # 23 & #24 with a syringe without a physician order and how to properly thicken residents food. CNA Instructor informed 5/14/12 by DON that students are not to use feeding devices unless properly trained. Use of feeding devices must be approved by DON prior to using	

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{F 278}	Continued From page 38 June 16, 2011, revealed "...restraints...low bed with padded rails...SR x (times) 2 when in bed...seizure disorder...if seizure occurs try to prevent injury..." Medical record review of the Physician Recapitulation Orders dated May 2012, revealed "...DX: Seizure Disorder..." Interview with MDS Coordinator on May 14, 2012, at 11:20 a.m., in the Director of Nursing (DON) office, confirmed the MDS for Resident's #1, #13, and #16 were not accurate. Resident #2 was admitted to the facility on October 10, 2010, with diagnoses including Behavior Disorder, Alzheimer's Disease, and Dementia. Medical record review of the admission MDS assessment dated November 4, 2012, revealed the resident was severely cognitively impaired, had a history of wandering, and required limited staff assistance with ADLs (activities of Daily Living). Continued MDS review revealed the resident was not coded for any type of physical restraint. Observation of Resident #2 on May 7, 2012, at 10:00 a.m., lying on the bed, with full side-rails up bilaterally. The resident's call light was within reach. There was a merry-walker at the resident's bedside. Observation on May 7, 2012, at 2:30 p.m., revealed the resident ambulating throughout the facility in a merry-walker. The resident had a seatbelt secured around the waist in the	{F 278}	special devices. This was added to the policy, "Assistance with Meals", and in-serviced to all RN's, LPN's, and CNA's 5/27/12-5/30/12. Any RN/LPN/CNA who has not attended the above in-service cannot work until they have attended an in-service. MDS Coordinator changed Resident #23 and #24 MDS assessment and Care Plan to reflect current status. This was begun 5/16/12 and completed on 5/29/12. On 5/29/12 MDS Coordinator then communicated Care Plan changes by memo to all RN's, LPN's, and CNA's after giving resident an opportunity to review plan of care. Any above RN/LPN/CNA not having read the memo cannot work until memo read and acknowledged. 2) On 5/15/12-5/16/12, DON or designee observed all other residents and no other residents were being fed with a syringe. On 5/16/12, all other residents who were receiving thickened liquids were checked for correct use of thickening ingredient. This was completed 5/16/12.	

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{F 278}	Continued From page 39 merry-walker, and the merry-walker had weights at the base to prevent the resident from tipping the device over. The resident was confused and mumbling to self. The resident could not exit the merry-walker independently when instructed to attempt. Observation on May 8, 2012, at 3:45 p.m., revealed the resident in the facility "circle area," in a reclined geri-chair with lap top tray secured across the lap. The resident was restless and attempting to exit the chair by leaning to the right. Interview with the DON, at the time of the observation, confirmed the recliner is a restraint with the tray table across the resident to prevent the resident from rising independently, the merry-walker and the seatbelt for the merry-walker, as well as the bed side rails in the up position, are all physical restraints. The DON further confirmed the comprehensive assessment was inaccurate. Resident #4 was admitted to the facility on June 2, 2008, with diagnoses including Schizophrenia, Depression, and Weakness. Medical record review of the MDS assessment dated February 9, 2012, revealed the resident with severe cognitive deficits, the resident was ambulatory with the use of a walker, and the resident had no restraint. Observation of the resident on May 9, 2012, at 8:20 a.m., revealed the resident lying on the bed with the left side of the bed against the wall and half side rails up, in the mid bed position, on the right side of the bed.	{F 278}	On 5/15/12, MDS Coordinator reviewed all other residents MDS Assessments and Care Plans for current status relating to thickened liquids. No other residents needed changes. 3) The DON/ADON will monitor residents monthly who require assistance with eating to ensure that no resident is being fed with a syringe without a physician order and proper evaluation by a Speech Therapist and thickened liquids are being used as ordered by MD or Dietician beginning 6/1/12. 4) The DON will report the outcomes of monitoring residents requiring assistance with eating and any swallowing difficulties at the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 278}	Continued From page 40 Observation of the resident on May 14, 2012, at 10:05 a.m., revealed the resident lying on the bed, with the side rail on the right side of the bed in the down position. The left side of the bed was against the wall. Interview with the DON, on May 15, 2012, at 11:25 a.m., at the nurse's station, confirmed the side rail on the right side of the bed is a restraint when in the up position, with the left side of the bed against the wall. The DON further confirmed the comprehensive assessment was inaccurate. Resident #14 was re-admitted to the facility on January 31, 2011, with diagnoses including Personality Disorder, Dementia with Behavior Disorder, and Spinal Stenosis. Medical record review of the resident's MDS assessment dated February 9, 2012, revealed the resident had severe cognitive deficits, was chair or bed bound, was ambulatory with the use of a wheelchair, and had no restraint. Observation of the resident in the "circle area" on May 9, 2012 at 1:00 p.m., revealed the resident in a reclined geri-chair with pillows to each side of the body. The resident was confused. Observation of the resident on May 14, 2012, at 9:45 a.m., revealed the resident in room in reclined geri-chair. Resident was anxious and confused, and was unable to exit the chair independently. Interview with the DON, at the time of the observation, confirmed the recliner is a restraint if	{F 278}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 278}	Continued From page 41 the chair prevents the resident from rising independently. The DON further confirmed the comprehensive assessment was inaccurate Resident #23 was admitted to the facility on October 2, 2008, with diagnoses including Dementia, and Osteoporosis. Medical record review of the MDS dated March 15, 2012, revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and a mechanically altered diet. Medical record review of an Interdisciplinary Care Plan dated last reviewed June 16, 2011, revealed "...assist with feeding as needed...honey thickened liquid 2/7/12..." Medical record review of a Resident Plan of Care Instructions, no date, revealed "...can be fed using a syringe..." Medical record review of a Dietician note dated March 26, 2012, at 4:13 p.m., revealed "...honey thick liquids...vegan/pureed...fed with syringe but sometimes won't open mouth..." Medical record review of a Physician Recapitulation Orders May 2012, revealed "...Diet - N/A (non applicable) honey thickened liquids..." Observation on May 15, 2012, at 8:05 a.m., in the activity room, revealed Resident #23 sitting in a wheel chair, Certified Nurse Assistant (CNA) #16 feeding the resident with a sixty cc (cubic	{F 278}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 278}	Continued From page 42 centimeters) syringe. Interview with CNA #16 on May 15, 2012, at 8:10 a.m., revealed the syringe contained pureed oatmeal, peanut butter, and milk. Observation with the DON on May 15, 2012, at 8:18 a.m., in the activity room, revealed CNA student #1 feeding Resident #23 with a syringe containing milk that had not been thickened and the DON instructed the student to thicken the milk. Observation on May 15, 2012, at 11:30 a.m., in the activity room, revealed the resident being fed by CNA #6 with a spoon. Interview with the DON on May 15, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to complete a feeding assessment to determine the need and safety of feeding the resident with a syringe. Resident #24 was admitted to the facility on May 1, 2009, with diagnoses including Cardiovascular Accident, Contracture, and Pain. Medical record review of a MDS dated March 22, 2012, revealed the resident was severely impaired for daily decision making, inattention present fluctuates, totally dependent on staff for eating, no swallowing disorder, and a mechanically altered diet. Medical record review of the Interdisciplinary Care Plan dated March 22, 2012, revealed "...mechanically altered diet...tolerate consistency of food without evidence of choking...pureed diet	{F 278}		

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{F 278}	Continued From page 43 texture...offer small bites...remind to swallow...monitor for S/SX (signs and symptoms) aspiration...use a sippy cup for all liquids..." Medical record review of a Dietitian note dated March 26, 2012, at 8:54 a.m., revealed "...takes a while to swallow...receiving honey thick liquids..." Medical record review of a Physician Recapitulation Orders May 2012, revealed "...Diet Pureed...honey thickened liquids..." Observation on May 15, 2012, at 11:30 a.m., in the resident's room, revealed the resident being fed by CNA #16 with a 60 cc syringe. Interview with the DON on May 15, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to complete a feeding assessment to determine the need for feeding the resident with a syringe. C/O #27230 #27265 #28092	{F 278}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	{F 279}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	{F 279}	**F 279 483.20(d)(k) Develop Comprehensive Care Plans** **Resident # 18** 1) The MDS Coordinator changed the above Resident's Care Plan to reflect current status. This was done on 5/16/12. On 5/28/12, the MDS Coordinator then communicated with the residents and POA concerning changes in Care Plan	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 279}	Continued From page 44 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for one resident (#18) of twenty-seven residents reviewed. The findings included: Resident #18 was admitted to the facility on March 1, 2006, with diagnoses including Senile Dementia, Osteoarthritis, Osteoporosis, Psychosis, Hypothyroidism, and Depressive Disorder. Medical record review of the Minimum Data Set (MDS) dated March 1, 2012, revealed the resident had short and long term memory problems, required extensive assistance with activities of daily living, and required extensive assistance with eating. Medical record review of a Dietary Progress Note dated May 23, 2011, revealed "...having to assist...more lately with eating...needs more encouragement..." Medical record review of a Dietary Progress Note	{F 279}	and provided an opportunity for input. The Care Plan changes were communicated by memo on 5/16/12-5/31/12 to all RNs, LPNs & CNAs. Any RNs & LPNs who have not acknowledged reading the above memo cannot work until they have signed the in-service sheet stating they have read the memo. Exhibit #72, 73 2) On 5/15/12 all other residents care plans were reviewed by the MDS Coordinator and then were revised as needed. The MDS Coordinator communicated the Care Plan changes by memo to all RN's, LPN's and CNA's. Any RN's, LPN's, CNA's who have not acknowledged reading the above memo cannot work until they have signed the in-service sheet stating they have read the memo. 3) The MDS Coordinator will monitor all MDS care plans for appropriate data and interventions beginning 5/29/12. A trending report was developed for reporting to the QAPI Committee. The DON will review four Care Plans per	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{F 279}	Continued From page 46 dated February 28, 2012, revealed "...cannot feed...self...requires encouragement drinking and eating..." Medical record review of a Dietary Progress Note dated May 9, 2012, revealed "...needs assistance w/ (with) eating..." Medical record review of a Care Plan last reviewed on March 1, 2012, revealed no care plan for assistance with meals. Observation on May 14, 2012, at 4:53 p.m., in the dining room, revealed the resident sitting at a dining table with an untouched supper tray sitting on the table and a spoon lying in the pureed meat. Continued observation at 4:56 p.m., revealed Certified Nursing Assistant (CNA) #13 scooped meat onto the spoon and laid the spoon back on the resident's plate. Continued observation revealed another resident sitting at the same table stated "pick up your spoon and eat." CNA #13 then walked away from the table. Continued observation revealed the resident continued to sit at the table not eating with the hands folded and resting on the lap. Continued observation at 5:09 p.m., revealed the resident continued to sit at the table not eating and no staff attempted to assist or encourage the resident to eat. Continued observation at 5:16 p.m., (twenty-three minutes later) revealed CNA #14 assisted the resident with eating. Interview with the Director of Nursing (DON) on May 14, 2012, at 5:10 p.m., in the dining room, confirmed "within five minutes I would expect staff to assist with feeding and attempt to encourage resident every couple of minutes."	{F 279}	month for correct, appropriate and timely interventions. Exhibit #74 4) The MDS Coordinator will monitor MDS care plans for correct and appropriate data and interventions quarterly. This was begun on 5/29/12 and will continue monthly for 6 months then as needed to ensure compliance has been achieved. The MDS Coordinator will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 279}	Continued From page 46 Interview with CNA #14 on May 14, 2012, at 5:16 p.m., in the dining room, confirmed the resident would self feed if (resident) liked the food, but "will eat food even if (resident) doesn't like it if someone feeds (resident)." Interview with the DON on May 15, 2012, at 1:05 p.m., outside the MDS Coordinator office, confirmed the facility failed to complete a comprehensive care plan to include assistance with meals.	{F 279}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	{F 280}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 279}	Continued From page 46 Interview with CNA #14 on May 14, 2012, at 5:16 p.m., in the dining room, confirmed the resident would self feed if (resident) liked the food, but "will eat food even if (resident) doesn't like it if someone feeds (resident)." Interview with the DON on May 15, 2012, at 1:05 p.m., outside the MDS Coordinator office, confirmed the facility failed to complete a comprehensive care plan to include assistance with meals.	{F 279}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	{F 280}	**F280 483.20(d)(3) 483.10 (k)(2) Right to Participate Planning Care-Revise CP** **Resident #1** **1)** MDS Coordinator changed the above Resident's MDS and Care Plan to reflect current status. This was done on 5/16/12 – 5/29/12. The MDS Coordinator corrected the MDS Assessment on the above resident on 5/15/12. The MDS Coordinator then communicated the Care Plan changes by memo to all RNs, LPNs & CNAs, starting 5/16/12 and completing on 5/29/12. Any RNs & LPNs who have not acknowledged reading the above memo cannot work until they have	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 280}	Continued From page 47	{F 280}	signed the in-service sheet stating they have read the memo.	

by:
Based on medical record review, observation, and interview, the facility failed to evaluate and update the care plan for one resident (#1) of twenty-seven residents reviewed.

The findings included:

Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder.

Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment and exhibited behaviors four to six days weekly.

Medical record review of the Care Plan dated March 15, 2012, revealed no intervention or medications for Seizure Disorder.

Medical record review of a Nurse's Note dated March 19, 2012, at 10:00 a.m., revealed "...having a seizure..."

Medical record review of a Nurse's Note dated May 19, 2012, revealed "...doctor notified of seizure..."

Medical record review of Physician Recapitulation Orders dated May 2012, revealed "...DX: (diagnosis) Seizure Disorder...Depakote (seizure medication) 500 mg (milligram) tablet...TID (three times a day)...Carbamazepine (seizure medication) 200 mg...TID..."

2) On 5/15/12 all other residents care plans were reviewed by the MDS Coordinator and then were revised as needed. The MDS Coordinator communicated the Care Plan changes by memo to all RN's, LPN's and CNA's. Any RN's, LPN's, CNA's who have not acknowledged reading the above memo cannot work until they have signed the in-service sheet stating they have read the memo.

3) The MDS Coordinator will monitor all MDS Assessments and care plans for appropriate data and interventions beginning 5/29/12. A trending report was developed for reporting to the QAPI Committee. The DON will review four assessment and four Care Plans per month for correct data, appropriate and timely interventions. The DON will review four assessments and four Care Plans per month for correct data, appropriate and timely intervention.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 280}	Continued From page 48 Observation on May 7, 2012, at 10:50 a.m., in the resident's room, revealed the resident sitting in an electric wheelchair, alert and oriented. Interview with the MDS Coordinator on May 14, 2012, at 11:28 a.m., in the Director of Nursing (DON) office, confirmed the care plan had not been updated to reflect interventions for Seizure Disorder and seizure activity. C/O #27265 #28092	{F 280}	4) The MDS Coordinator will monitor MDS Assessment and care plans for correct and appropriate data and interventions quarterly. This was begun on 5/29/12 and will continue monthly for 6 months then as needed to ensure compliance has been achieved. The MDS Coordinator will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to write and follow a physican's order for vital signs and neurological checks for one resident (#19) and failed to obtain a physician's order prior to administering medication to one resident (#20) of twenty seven residents reviewed. The findings included: Resident #19 was admitted to the facility on October 22, 2010, with diagnoses including Diabetes Mellitus Type 2, Chronic Catatonia, Dehydration, and Venous Thrombosis. Medical record review of the Minimum Data Set (MDS), dated March 3, 2012, revealed the	{F 281}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 280}	Continued From page 48 Observation on May 7, 2012, at 10:50 a.m., in the resident's room, revealed the resident sitting in an electric wheelchair, alert and oriented. Interview with the MDS Coordinator on May 14, 2012, at 11:28 a.m., in the Director of Nursing (DON) office, confirmed the care plan had not been updated to reflect interventions for Seizure Disorder and seizure activity.	{F 280}		
{F 281} SS=D	C/O #27265 #28092 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to write and follow a physican's order for vital signs and neurological checks for one resident (#19) and failed to obtain a physician's order prior to administering medication to one resident (#20) of twenty seven residents reviewed. The findings included: Resident #19 was admitted to the facility on October 22, 2010, with diagnoses including Diabetes Mellitus Type 2, Chronic Catatonia, Dehydration, and Venous Thrombosis. Medical record review of the Minimum Data Set (MDS), dated March 3, 2012, revealed the	{F 281}	**F 281 483.20(k)(3)(i) Services Meet Professional Standards** **Resident # 19** 1) The DON will review policy on Accidents and/or Incident when residents hit their head to ensure that all residents have orders for neuro checks and neuro checks are completed. The DON or RN/BSN conducted an in-service with all RNs and LPNs on use of Accident/Incidents, Clinical Protocol. This was done on 5/27/12 -5/29/12. The policy "Accident/Incidents, Clinical Protocol" was provided to each RN & LPN on 6/1/12 to reinforce the in-services conducted on the above	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 281}	Continued From page 49 resident was moderately cognitively impaired and required extensive assistance with activities of daily living, toileting and bathing. Medical record review of a Nurse's Note dated December 22, 2011, at 7:30 a.m., revealed "...resident in bath room in shower chair. Certified Nurse Assistant (CNA) observed resident fall sideways out of the shower chair, landing on the right side. Resident was assessed for injuries, small contusion noted to right side of forehead. No other injuries noted. Neuro checks started..." Medical record review of the "Vital Sign Flow Sheet with Neuro Checks" dated December 23, 2011 and December 24, 2011, revealed"...frequency q (every) 4 hours per shift for 24 hours, then qs (every shift) X (times) 24 hours..." Medical record review of the Physician's Order sheet for December 23, 2011 or December 24, 2011, revealed there was no order written for the vital signs or the neuro checks. Medical record review of the Vital Signs Flow Sheet revealed on December 24, 2011, at 8:00 a.m., 4 p.m. and 10 p.m., no vital signs or neuro check information was documented on the resident's record. Observation on May 14, 2012, at 4:55 p.m., in the resident's room, revealed the resident sitting in the wheelchair with a clip alarm in place. Telephone interview with Licensed Practical Nurse (LPN) #5, on May 15, 2012, at 10:30 a.m., revealed "...I called the doctor about the fall and	{F 281}	dates. Any RN, LPN who have not attended the above in-service cannot work until they have attended an in-service on policy "Accident/Incidents, Clinical Protocol. 2) On 5/15/12 to 5/29/12, all other residents were assessed. On 6/1/12 an audit was conducted on resident who had neuro checks, all resident's had orders and neuro checks were done. 3) The DON or designee will monitor all falls for completed neuro checks beginning 6/1/12. This policy "Accident/Incidents, Clinical Protocol" will be in-serviced quarterly for the next 6 months beginning 6/1/2012. This policy will be part of orientation of new employees beginning 6/1/12. 4) The DON or designee will monitor use of neuro checks monthly for 100% compliance. This was begun on 5/15/12 and will continue weekly for 6 weeks then as needed to ensure compliance has been achieved. The DON will report the outcomes to the next	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 281}	Continued From page 50 received orders for the vital signs and the neuro checks for every 4 hours for the first 24 hours, then every shift for 24 hours...I forgot to write the order and communicate this to the oncoming shift..." Interview with the Director of Nursing (DON) and the MDS Coordinator on May 14, 2012, at 3:30 p.m., in the DON office, confirmed the physicians telephone order was not transcribed for the vital signs or the neurological checks and the facility failed to follow the Physician's Order or obtain the neuro checks on December 24, 2011. Resident #20 was admitted to the facility on May 1, 2012, with diagnoses including Anemia, Osteoporosis, Cerebral Vascular Accident, Transient Ischemic Attacks, and Cataract Repair. Observation on May 15, 2012, at 9:30 a.m., in the west hallway, revealed LPN #4, preparing multiple herbal medications to administer to Resident #20, including Dandelion Leaf, Hawthorn Berry, Turmeric, Bilberry Leaf, and Vitamin C. Further observation revealed the medications were stored in zip lock bags labeled with the herbal medication name and strength, if applicable, and did not include the resident's name, medication expiration date, ordering physician's name, dispensing instructions, or pharmacy label. Medical record review of the Medication Administration Record for May 2012, revealed the resident received all the herbal medications daily from May 2 through 15, 2012. Medical record review of the Physician's Orders	{F 281}	quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. **Resident #20** 1) Upon being made aware of LPN #4's deficient practice of administering herbal medication without a physician order, an in-service was conducted on the correct policy " Herbal Medication Policy" stating that all medications must have a physician orders including herbal medications brought to facility by resident or family members. This was done on 5-15-12. The DON will observe LPN # 4 randomly on a monthly basis until 100% compliance is met. This was begun on 6/1/12. The Pharmacy Service was changed effective 6/1/12. The Pharmacy Consultant will assist in capturing physician orders for all medications administered and recorded on MAR beginning 6/1/12. 2) 5/15/12 to 5/16/12, DON/ADON surveyed the other medication cart to ensure no other residents were	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 281	identified to ensure no herbal medications were being administered without a physician order. No other residents were identified as needing an order. On 5/29/12 the RN/BSN staff in-serviced all other licensed staff on "Verbal and Written Orders – General. **3)** Medication Pass will be observed by the DON or designee beginning 6/1/12 to ensure that the facility policy and state laws are observed including physician orders for all medications. The Pharmacy consultant will assist in Med Pass observations of RNs & LPNs administering medications within the facility beginning 6/1/12. The DON or designee will monitor medication administration to ensure resident's medications have physician orders. This was begun on 5/29/12 and will continue weekly for 4 weeks then monthly on a random basis to ensure compliance has been achieved. **4)** The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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OMB NO. 0938-0391

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{F 281}	Continued From page 51 for May 2012, revealed no order from the resident's physician for the herbal medications. Interview on May 15, 2012, at 1:30 p.m., with LPN #2, confirmed the herbal medications were brought to the facility in zip lock bags by the resident and had been administered daily during May 2012, without a Physician's Order.	{F 281}	Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to control pain for one resident (#18) and failed to follow physician's orders for one (#7) of twenty-seven residents reviewed. The findings included: Resident #18 was admitted to the facility on March 1, 2006, with diagnoses including Senile Dementia, Osteoarthritis, Osteoporosis, Psychosis, Hypothyroidism, and Depressive Disorder. Medical record review of the Minimum Data Set (MDS) dated March 1, 2012, revealed the resident had short and long term memory	{F 309}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 281}	Continued From page 51 for May 2012, revealed no order from the resident's physician for the herbal medications. Interview on May 15, 2012, at 1:30 p.m., with LPN #2, confirmed the herbal medications were brought to the facility in zip lock bags by the resident and had been administered daily during May 2012, without a Physician's Order.	{F 281}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to control pain for one resident (#18) and failed to follow physician's orders for one (#7) of twenty-seven residents reviewed. The findings included: Resident #18 was admitted to the facility on March 1, 2006, with diagnoses including Senile Dementia, Osteoarthritis, Osteoporosis, Psychosis, Hypothyroidism, and Depressive Disorder. Medical record review of the Minimum Data Set (MDS) dated March 1, 2012, revealed the resident had short and long term memory	{F 309}	**F 309 483.25 Provide Care/Services for Highest Well-Being** **Resident #1** 1) DON reviewed the Pain Assessment policy and revised the policy on 5/25/12 to ensure that all residents have their pain managed appropriately. The following additions to the Pain Policy included: 1) Call physician within two hours if no change in character or intensity of pain. 2) A list of non-medication interventions for pain. The DON conducted an in-service with all RNs and LPNs on the newly revised "Pain Assessment, Reassessment and Management Policy" on 5/28/12 & 5/29/12. Any RN and LPN who have not attended the above in-service cannot work until they have	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 309}	Continued From page 52 problems, and required extensive assistance with ambulation and activities of daily living. Medical record review of a Nurse's Progress Note dated September 25, 2011, revealed "...resident climbed between bedrail and footboard...observed sitting on the floor..." Medical record review of a Radiology Report of the pelvis dated September 25, 2011, revealed, "...severe osteoarthritis of both hips...no acute fracture is appreciated..." Medical record review of a Nurse's Progress Note dated September 25, 2011, at 12:30 p.m., revealed, "...resident returned from (Hospital)...discharge instructions...return in 6-8 hours if pain does not improve..." Medical record review of a Nurse's Progress Note dated September 25, 2011, at 10:01 p.m., revealed, "...Pt (patient) yells when turned by staff members..." Further review of a Nurse's Progress Note dated September 26, 2011, at 6:53 a.m., revealed, "...resident showed extreme pain during shift rotations and during get-up time...resident given 1000 mg (milligram) of Tylenol...no improvement in pain..." Further review of a Nurse's Progress Note dated September 26, 2011, at 1:17 p.m., revealed, "...resident complains of pain when walking...given pain medication...still 2 hrs (hours) later in excoriating (excruciating) pain..." Continued review of a Progress Note at 4:30 p.m., revealed, "...physician contacted due to	{F 309}	attended an in-service on Pain Assessment, Reassessment and Management . Exhibit # 44 2) On 5/29/12 all other residents receiving pain medications were assessed for appropriate pain control by the DON. All other residents' pain was appropriately controlled during assessment. On 6/1/12, the policy, "Pain Assessment, Reassessment, and Management", was posted on the nursing bulletin board as a reminder of facility practice. This policy will be in-serviced quarterly for the next six months beginning 6/1/12. 3) The DON or designee will monitor residents receiving pain medication to ensure residents' pain is managed appropriately. On 5/29/12, a Medical Record Review worksheet was developed to monitor pain management. This review will be conducted monthly for three months or until substantial compliance is obtained. This policy will be in-serviced quarterly for the next 6 months beginning 6/1/12.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 309}	Continued From page 53 patient's severe R (right) leg pain...order given for Lortab (narcotic)..." Medical record review of a facility Medication Record dated September 2011 and October 2011, revealed Lortab was administered for pain management. Medical record review of a Nurse's Progress Note dated September 27, 2011, at 12:56 a.m., revealed, "...still in tremendous pain...yelling when turned...or change of position..." Continued review of a Nurses's Note at 4:14 p.m., revealed, "...screaming out in pain when care done..." Medical record review of a (mobile imaging) Patient Report of the right femur (hip) xray dated September 27, 2011, revealed, "...no fracture is seen..." Medical record review of a Nurse's Progress Note dated September 30, 2011, at 6:48 a.m., revealed, "...slept through the night...c/o (complains of)...hurts up inside..." Medical record review of a Physician's Note dated October 5, 2011, revealed, "...had a fall last week and xray was no fx (fracture) noted but continued pain..." Medical record review of a Nurse's Progress Note dated October 5, 2011, at 11:06 a.m., revealed, "...seen by (medical director) new orders for x-ray of right femur..." Continued review of a Nurse's Progress Note dated October 6, 2011, at 11:39 a.m., revealed, "...received results...acute fracture...send to	{F 309}	4) The DON or designee will report to the QAPI Committee the outcomes of the results of resident's pain control. This was begun on 5/29/12 and will continue weekly for 6 weeks then as needed to ensure compliance has been achieved. The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. **Resident # 7** **Discharged from facility 2/5/2012** 1) DON reviewed the policy "Guidelines for Notifying Physician of Clinical Problems" on 5/25/12, and added dialysis treatment. On 5/27/12 & 5/28/12 the DON conducted an in-service with all RNs and LPNs on the "Guidelines for Notifying Physician of Clinical Problems" to ensure that residents received the ordered care timely. Any RN and LPN who have not attended the above in-service cannot work until they have attended the above mentioned in-service.	

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{F 309}	Continued From page 54 (hospital) to consult orthopedic..." Medical record review of the Nurses' Progress Notes, Physician's Progress Notes, or Physician's Orders revealed no documentation addressing interventions for the resident's continued pain from September 27, 2011 through October 6, 2011. Resident #7 was admitted to the facility on March 29, 2010, with diagnoses including End Stage Renal Disease, Cerebrovascular Accident With Left Side Hemiparesis, Diabetes, and Hypertension. The resident was discharged from the facility on February 13, 2012. Medical record review of a Nursing Progress Note dated September 7, 2011, revealed, "...Resident to Dr. (Doctor) appointment at 9:00 a.m...Staff members has tried to contact (named hospital) 3 or 4 times to see if (resident) is coming back today..." Medical record review of a Nursing Progress Note dated September 22, 2011, revealed, "...Pt. (patient) returned from (named hospital) via ambulance at 6:30 p.m..." Medical record review of the Physician's Orders dated September 22, 2011, revealed, "...HD (Hemodialysis) on Tu (Tuesday)/Th (Thursday)/Sat (Saturday) per (named dialysis clinic)..." Medical record review of a Nursing Progress Note dated September 24, 2011, at 6:00 a.m., revealed	{F 309}	Exhibit # 45 2) On 5/29/12 the DON assessed all other residents for ordered care being provided by outside provider in a timely manner, ie. Dialysis Treatment. There were no other resident affected by this deficient practice. On 6/1/12 the policy "Guidelines for Notifying Physicain of Clinical Problems" was posted on the nursing's bulletin board as a reminder of facility practice. This policy will be in-serviced quarterly for the next 6 months beginning with 6/1/12. 3) The DON or designee will monitor monthly any resident receiving outside services by providers i.e. Dialysis to ensure residents receive their ordered care. This was begun on 5/29/12. This policy "Guideline for Notifying Physician of Clinical Problems" will be in-serviced quarterly for the next 6 months beginning 6/1/12. This policy will be part of orientation of new employees beginning 6/1/12.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 309}	Continued From page 55 "...scheduled for dialysis at (named dialysis clinic) today at 3PM...will be going by ambulance...At 4:00 pm...spoke with...(named dialysis clinic) re: (regarding) No transportation to the clinic today. (Dialysis Clinic) will try to work (resident) in on Monday..." Medical record review of a Nursing Progress Note dated September 26, 2011, revealed, "...called (named hospital) to talk with resident's case manager...to ask the reason why resident wasn't picked up on 9-24-11 for Dialysis...(case manager) wasn't there another case manager...called me back to say...was looking into the problem...called (dialysis clinic)...(dialysis clinic) stated they were set to take (resident) but... (named ambulance) stated that (named hospital) had not sent the medical necessity form to them yet to transport...(named ambulance) called and said they will pick up resident on 9-27-11..." Medical record review of a Nursing Progress Note dated September 27, 2011, revealed "...was taken via ambulance around 2PM to go to (named dialysis clinic) but was deferred to (named hospital) on the way due to resident blood sugar being too low..." Medical record review of a Nursing Progress Note dated September 28, 2011, revealed "...Taken, via...ambulance to...schedule dialysis appointment..." Medical record review of a Nursing Progress Note dated September 28, 2011, revealed "...Received phone call...at dialysis clinic to report that...had given Res (resident) 3 amps of D50% (Dextrose 50%) res. Blood sugar was in the 30s and they	{F 309}	4) The DON or designee will report to the QAPI Committee any issues with outside provider in providing resident care. This was begun on 5/29/12 and will continue weekly for 6 weeks then as needed to ensure compliance has been achieved. The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

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{F 309}	Continued From page 56 got it to come up but it kept dropping. Res. being transported via ambulance to (named hospital) per POA (power of attorney) request..." Medical record review of a Nursing Progress Note dated October 1, 2011, revealed "...Pt. returned from (named hospital)..." Interview on May 8, 2012, at 8:45 a.m., with the Director of Nursing, in the therapy room, confirmed the Physician's Orders were not followed to ensure the resident received dialysis on September 24, 2011. c/o #28839	{F 309}		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to identify a pressure ulcer and failed to provide treatment timely for a pressure ulcer which caused harm for one resident (#6) and failed to provide treatment timely for a pressure ulcer for one resident (#7) of twenty-seven	{F 314}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 309}	Continued From page 56 got it to come up but it kept dropping. Res. being transported via ambulance to (named hospital) per POA (power of attorney) request..." Medical record review of a Nursing Progress Note dated October 1, 2011, revealed "...Pt. returned from (named hospital)..." Interview on May 8, 2012, at 8:45 a.m., with the Director of Nursing, in the therapy room, confirmed the Physician's Orders were not followed to ensure the resident received dialysis on September 24, 2011. c/o #28839	{F 309}		
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to identify a pressure ulcer and failed to provide treatment timely for a pressure ulcer which caused harm for one resident (#6) and failed to provide treatment timely for a pressure ulcer for one resident (#7) of twenty-seven	{F 314}	**F 314 483.25(c) Treatment /Services to Prevent/Heal Pressure Sores** **Resident #6** 1) Upon notification of the delay in appropriate wound care for Resident #6, policies and procedures were reviewed by DON/Wound Care Nurse on 5/28/12. Revisions were made to ensure all wounds will be addressed as soon as they are found. A packet was developed by Wound Care Nurse on 5/27/12 that contains a checklist for the nurse who finds the wound to initiate treatment. An in-service was provided on 5/29/12	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 314}	Continued From page 57 resident's reviewed. The findings included: Resident #6 was admitted to the facility on July 12, 2011, with diagnoses including B-Cell Lymphoma, Diabetes, Depression, Gout, and Peripheral Vascular Disease. Medical record review of a Nursing Progress Note dated April 21, 2012, revealed, "...Weekly skin assessment done: assessed all areas of the skin with clothes off paying special attention to bony areas, under arms, breasts, groin, buttocks, arms and legs-resident has small red area to back of left leg, just below buttock. No other wounds noted... " Medical record review of a Physical Therapist Progress Note dated April 25, 2012, revealed, "...Pt. (patient) is saying that ...thinks...could walk just as well if not better without the thigh brace on left. Also stating that entire shoe will have to be replaced on the left b/c (because) it is too tight...does not like the therapist to pull the straps tight but prefers them lose (loose). I told (resident) I cannot allow them to be lose due to too much friction and slipping in the shoe...has an open wound on 2nd dorsal toe which is bandaged. Medical record review of a Nursing Progress Note dated April 28, 2012, revealed, "...weekly skin assessment done...small spot with loose skin around seemingly old wound on back of left thigh right below left buttock, no redness...looks healed...Second and fourth digits of left foot with band-aids. Resident refused to have them removed for assessment...no signs of	{F 314}	and 5/30/12 for all RNs & LPNs regarding the new packet. Any RN/LPN who has not attended the above in-service cannot work until they have attended an in-service. Wound Care policies were approved by QAPI Committee on 5/27/12. 2) On 5/29/12, Wound Care Nurse assessed all other residents to ensure no other unidentified wounds could be found. This includes Resident #6. No other residents identified as needing an order. 3) The DON/Wound Care Nurse will monitor all wounds to ensure all wounds are promptly addressed and treated, effective 5/29/12. The policies on Wound Care and Treatment will be in-serviced quarterly for the next six months beginning 6/1/12. This policy will be part of orientation of new employees beginning 6/1/12. 4) The DON will report the Wound Care outcomes quarterly to the QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 314}	Continued From page 58 inflammation noted around band-aids. No other wounds noted..." Medical record review of a wound assessment worksheet dated May 3, 2012, revealed 1st toe left foot with redness, 2nd toe left foot with redness, 3rd toe left foot measured 1.3 cm (centimeters) length and 1.2 cm width, wound base with eschar/slough. Medical record review of a physician's order dated May 3, 2012, revealed, "...Santyl to toes daily. Cover with light dressing...Vitamin C 500mg (milligrams) po (by mouth) BID (twice a day) x 2 wks (weeks) Zinc 200mg po Q (every) day x (times) 2 wks check Albumin level if low...start protein powder 2 scoops Q day x 2 wks..." Medical record review of a Medication Record dated May 2012, revealed "Santyl to open wound on toes of L (left) foot Q day cover (with) light dressing..." Further review of the Medication Record dated May 2012 revealed treatment to the toes was not initialed as provided until May 3, 2012. Medical record review of a Nursing Progress Note dated May 6, 2012, revealed "...Weekly skin assessment done...3 toes on Lt (foot) have rub abrasions which are being treated as ordered..." Medical record review of a wound assessment worksheet dated May 9, 2012, revealed, "...(left) foot...Stage 2...Eschar/Slough...first toe L (length) 0.2 W (width) 0.2 D (depth) 0...2nd toe L 0.1 W 0.1 (no depth)...3rd toe L 0.3 W 0.4 D 0..." Medical record review of a wound assessment	{F 314}	QAPI Committee meeting is 6/20/12. **Resident #7** Resident discharged from facility 2/4/2012 **1)** Upon notification of the delay in appropriate wound care for Resident #7, policies and procedures were reviewed by DON/Wound Care Nurse on 5/28/12, revisions were made to ensure all wounds will be addressed as soon as they are found. A packet was developed by the Wound Care Nurse 5/27/12 that contains a checklist for the nurse who finds the wound to initiate treatment. An in-service was provided on 5/29, 5/30, 5/31/12 for all RN & LPN's regarding the new Wound Care packet. Any RN/LPN who has not attended the above in-service cannot work until they have attended an in-service. Wound Care policies were implemented by QAPI Committee on 5/27/12 and an updated in-service given to nurses on 6/1/12 for implementation. Exhibit 75, 76	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	44E200	A. BUILDING _____ B. WING _____	R 06/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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{F 314}	Continued From page 60 Left Side Hemiparesis, Diabetes, and Hypertension. The resident was discharged from the facility on February 13, 2012. Medical record review of a Nursing Progress Note dated September 22, 2011, revealed, "...Pt. (patient) returned from (named hospital) via ambulance at 6:30 p.m..." Medical record review of a Nursing Home Physician's Order from the hospital dated September 22, 2011, revealed, "...cont (continue) L (left) leg decubitus ulcer care per...wound care orders..." Medical record review of a Nursing Progress Note dated September 23, 2011, revealed, "...Received report that resident had returned to facility with decubitus ulcers. Stage 1 to sacral area, left heel (and) ankle. Stage 2 to left calf. Treatment nurse to evaluate (and) obtain MD (Medical Doctor) orders for treatment...Please disregard stage 2 ulcer as noted above. Further evaluation reveals that resident came back with an unstageable ulcer..." Medical record review of a Physician's Order dated September 27, 2011, revealed, "...Santyl to LLE (left lower extremity) wounds, cover with Aquacel Ag and Kerlix daily..." Medical record review of the Wound Assessment Worksheet dated September 28, 2011, revealed, "...L heel...Length 1.7 cm (centimeters) Width 1.7 cm Depth (question mark)...Eschar...(upper) L ankle...Length 0.8 cm Width 0.4 cm Depth	{F 314}	2) On 5/29/12, Wound Care Nurse assessed all other residents to ensure no other unidentified wounds could be found. This included Resident #6. No other residents identified as needing an order. 3) The DON/Wound Care Nurse will monitor all wounds to ensure all wounds are promptly addressed and treated, effective 5/29/12. The policies on Wound Care and Treatment will be in-serviced quarterly for the next six months beginning 5/29/12. This policy will be part of orientation of new employees beginning 6/1/12. 4) The DON will report the Wound Care outcomes quarterly to the QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

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{F 314}	Continued From page 61 (question mark)...Eschar...L calf...Length 1.7 cm Width 3.0 cm Depth 0 cm...Slough..." Medical record review of the Treatment Record (undated) revealed, "...L heel-clean (with) wound cleaner, santyl to Eschar. Cover with Aquacel Ag (and) cover (with) kerlix Q (every) day...L ankle: clean (with) wound cleaner apply santyl, Aquacel Ag (and) cover (with) kerlix...L calf-posterior aspect: santyl to wound, cover (with) Aquacel Ag (and) kerlix ..." Continued review revealed treatment was not initialed as provided until the 27th. (September, 2011) Medical record review of a Progress Note Report dated January 27, 2012, revealed, "...Skin Integrity No alterations..." Interview on May 8, 2012, at 8:40 a.m., with the Director of Nursing, in the therapy room, confirmed wound care was not provided until physician orders were obtained on September 27, 2011. Interview on May 14, 2012, at 11:25 a.m., with the Wound Care Nurse, at the nursing station, confirmed the nurse was not aware of the wound care orders when discharged from the hospital on September 22, 2011. c/o #28639	{F 314}		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	{F 323}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

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{F 314}	Continued From page 61 (question mark)...Eschar...L calf...Length 1.7 cm Width 3.0 cm Depth 0 cm...Slough..." Medical record review of the Treatment Record (undated) revealed, "...L heel-clean (with) wound cleaner, santyl to Eschar. Cover with Aquacel Ag (and) cover (with) kerlix Q (every) day...L ankle: clean (with) wound cleaner apply santyl, Aquacel Ag (and) cover (with) kerlix...L calf-posterior aspect: santyl to wound, cover (with) Aquacel Ag (and) kerlix ..." Continued review revealed treatment was not initialed as provided until the 27th. (September, 2011) Medical record review of a Progress Note Report dated January 27, 2012, revealed, "...Skin Integrity No alterations..." Interview on May 8, 2012, at 8:40 a.m., with the Director of Nursing, in the therapy room, confirmed wound care was not provided until physician orders were obtained on September 27, 2011. Interview on May 14, 2012, at 11:25 a.m., with the Wound Care Nurse, at the nursing station, confirmed the nurse was not aware of the wound care orders when discharged from the hospital on September 22, 2011. c/o #28839	{F 314}		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	{F 323}	**F323 483.25(h) Free of accident hazards/supervision/devices** 1) After being informed of the facilities failure to ensure that the resident's environment remains as	6/ /12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

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{F 323}	Continued From page 62 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, review of the facility investigation, review of the manufacturer's information, observation, and interview, the facility failed to provide supervision to prevent accidents for eight (#5, #4, #18, #3, #2, #14, #19, #21, #26) residents of twenty-seven residents reviewed. The facility's failure to supervise to prevent accidents placed residents #18, #3, #2, #4, #14, #19, #26 in Immediate Jeopardy. (Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation, has caused or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on May 30, 2012. A revisit conducted on June 4 - June 5, 2012, revealed the corrective actions implemented on May 30, 2012, removed the Immediate Jeopardy. Non-compliance for F-323 continues at an "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff, including administrative staff.	{F 323}	free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents, the following was put in place Resident # 5 Resident #5 discharged on 2/5/11. On 5/27/12 the DON revised and developed new Behavior Management and Monitoring Policies to address residents identified as having problematic behaviors that would need psychiatric consultation and behavioral management. These policies include Behavior Assessment and Monitoring, use of Restraints and Unmanageable Residents. Residents admitted with a history of impaired cognition, problematic behaviors, or mental illness will have a Geropsych Practitioner Consult (noted in policy). Policies were approved by Medical Director and QA Committee on 5/27/12. In-services were conducted on revised Behavior Management	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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{F 323}	Continued From page 63 The facility provided evidence Resident #5 was discharged from the facility on February 5, 2011. The facility provided evidence of a revised Behavioral Management Program, specific to Residents with problematic behavioral needs requiring psychiatric and behavioral management. Included in this program were Behavioral Assessment and Monitoring; Unmanageable Residents; Guidelines for Physician Notification; and Use of Restraints. The Medical Director evaluated all Residents with psychoactive medications and Residents with behavioral diagnoses; and the Geriopsych provider consulted with Residents with a history of impaired cognition, behavioral episodes, and/or mental illness. The facility provided evidence of completed Side Rail Assessments, Pre-Restraint and Restraints Assessments, and Informed Consents for restraint usage. Facility policies identify Side Rail Assessments will be completed upon admission and quarterly, thereafter. Pre-Restraint Assessments will be completed prior to restraint application; and Restraint Assessments will be completed quarterly. The facility's Fall Prevention Program included approaches to evaluate and identify appropriate interventions to prevent falls; Fall Checklist; Post-Fall Nursing Assessment; Post-Fall Investigation; Occurrence Investigation Statement; and Physical Therapist Screen (Residents with falls). The program included "Fall Prevention and Potential Interventions" and	{F 323}	Policies and Guidelines for Notification of Physician for Problematic Behaviors and other issues that address residents not responding satisfactorily to treatments on 5/28/12 & 5/29/12. Inservices given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Resident # 4 The resident was treated at the hospital following incident and returned to the facility on 2/5/2011. On 05/27/12 the DON revised and developed new Behavior Management and Monitoring Policies to address problematic resident behaviors that need psychiatric consultation and behavior management. These policies include the following: Behavior Assessment and Monitoring; Unmanageable	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 64. "Strategies for Reducing the Risk of Falls" which were posted at the Nurse's Station as a resource for the staff. The facility provided evidence of a Resident Fall Investigation, which was investigated timely, with appropriate interventions, to include notifications to the Physician and family, and the care plan was revised; the facility's investigation and response to the fall was thorough, and in accordance with the facility's revised policies and procedures. The facility provided evidence of care plan reviews to ensure appropriate behavioral and fall prevention interventions. The facility provided evidence of in-services related to policies and procedures for Behavior Assessment and Monitoring Program; Incidents and Accidents; Falls Prevention Program (Falling Leaf); Restraint Use and Management; Accident and Incidents Clinical Protocol for Conducting Neuro-Checks (falls with head injury and/or un-witnessed falls); and Hoyer Lift and Transfers. Observation of the Residents throughout the follow-up visit revealed facility staff approached and interacted appropriately with the Residents, according to the facility's Behavioral Management Program. Continued observation of random Residents with side rails and/or restraints, confirmed the facility's policies were followed in accordance with restraint usage, to include assessment for the safest and least restrictive device, informed consents, and care plan revision.	{F 323}	Residents. Residents admitted with a history of impaired cognition, problematic behavior or mental illness will have a Geropsych Practitioner Consult (noted in policy). Policies were approved by Medical Director and QA Committee on 5/27/12. Inservices given 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 19 <u>Resident # 18</u> On 05/15/2012 the DON implemented a new Side Rail Assessment to be conducted on all new admissions and quarterly thereafter. This form was approved by the Medical Director and QA Committee on 5/27/12. On 5/17/12 Resident # 18 was evaluated by DON for 1/4 side rails and these	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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		F 323	rails were applied on 5/17/12. Resident was placed on a new facility bed that allowed staff to place bed in low position. Use of Restraint policy was developed by DON and approved by the Medical Director and QA Committee on 5/27/12. No restraints can be applied without approval of DON/ Medical Director. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. <u>Resident #3 & #2</u> Resident # 3 is no longer a resident at the facility. The Abuse Investigation and Incident and Accident, Investigating and Reporting policies were reviewed and revised by the DON and Healthcare Consultant on	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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		F 323	5/27/12. The Healthcare Consultant inserviced these policies with the DON, Administrator and Medical Director on 5/28/12 emphasizing the importance of timely investigations and capturing all incidents. Inservices given on 5/27/12-5/30/12 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 20 <u>Resident # 2, #14, #19 , #26</u> A Falls Prevention Program called The Falling Leaf Program was developed by the interdisciplinary team in January 2012 and Physical Therapy is responsible for this program. This has been reviewed and revised on 5/27/12 to provide staff and interdisciplinary team members with an approach to evaluating and identifying appropriate interventions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		F 323	New forms and revised process for investigating falls have been developed and implemented 5/28/12. Fall checklist, post fall Nursing Assessment, post Fall Investigation, Occurrence Investigation Statement were approved by the DON, Administration and Medical Director on 5/28/12. Beginning 5/28/12 the Physical Therapist began screening residents with falls. The revised post Fall Investigation Form has possible Preventative Measures and suggested interventions that can aid licensed staff with implementing appropriate interventions. Also Fall Prevention and Potential Interventions and Strategies for Reducing the Risk for Falls were posted at the Nursing Station as a resource for selection of interventions if a fall occurs. This was done 5/29/12 by DON. The Falls Prevention Program includes a quarterly assessment of resident rooms and bath equipment conducted by maintenance staff for needed repairs. This assessment was begun January 2012 and revised 05/29/2012 to capture the	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	**114 CAMPUS DRIVE DAYTON, TN 37321**

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		F 323	appropriate documentation for repairs. Inservices given; 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. The newly created falls checklist has a notation to remind the staff to notify PT of falls. The Falls Prevention and Potential Interventions were placed at the nurse's station 5/28/12. New forms and revised process for investigating falls, and the the revised post falls investigation forms were inserviced to RN's, LPN's, and CNA's 5/28/12-5/30/12 by DON and RN/BSN. The DON is responsible for the overall Falls Prevention Program, effective 5/29/2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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		F 323	The Accident and Incidents Clinical Protocol policy for conducting Neuro checks following incidents where residents may have suffered head injury during the fall or an un-witnessed fall, was revised to follow facility policy. All residents experiencing falls will be monitored for 72 hours including Neuro checks according to facility policy. DON or designee will monitor this process effective 5/16/12. In-services given 5/27/2012-5/30/2012 on Fall Prevention Program, Accident/Incidents; Neuro checks to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will not be able to work until in-services are complete. DON/RN will oversee in-services and report to QA/PI. Exhibit # 22 Resident # 21 After being informed by surveyor that CNA #12 had transported Resident # 21 from shower room, in	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

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		F 323	a Hoyer lift, with the wrong sling, the DON conducted a teachable moment with CNA #12 on 5/14/12 and other staff working that day teaching that residents must not be transported down the hallway when residents are in the Hoyer lift. The Hoyer lift policy was reviewed with all staff working on the 7-3 and 3-11 shift by the DON on 5/16/12. All other licensed staff were then inserviced between 5/27/12-5/30/12. Exhibit # 23 **2)** The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. Inservices given from 5/27/2012-5/30/on Hoyer Lift to all RN's, LPN's, CNA's,. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. All residents received a Side Rail Assessment by a licensed nurse to determine appropriate use of side rails and restraints on those residents identified as being restrained by the use of side rails,	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

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LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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		F 323	Geri chairs, merry-walkers or specialized wheelchairs. They received a pre-restraint assessment and an informed consent was obtained. This process was begun on 5/15/12 and was completed on 5/29/12 with Medical Director and DON approval. Inservices given 5/27/2012-5/30/2012 on Restraint Management; Side Rail Assessment; Informed Consent and Behavior Assessment and Management to all RN's, LPN's, CNA's. Staff not in attendance will not be able to work until in-services are complete. DON/RN will oversee in-services and report to QA/PI. Exhibit # 9 The following policies or procedures have been changed by the DON and approved by Medical Director and QA Committee on 5/27/12 to address these deficiencies and practices: -Use of Restraints -Behavior Assessment and Monitoring -Side rail Assessment on Admission and Quarterly -Abuse Investigation -Resident Rights	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	R 06/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

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		F 323	Inservices given 5/27/2012-5/30/2012 on Use of Restrains; Behavior Assessment and Monitoring; Side Rail Assessment, Admission and Quarterly; Investigation to all RN's, LPN's, CNA's. Resident Rights was given to all Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 10 Teachable moments/in-services were conducted by DON on 5/24 and 5/25/12 on the following topics: -Resident Rights and Dignity -Restraints ie Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary,	

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		F 323	Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 11 Beginning 5/22/12 the Physical Therapist began screening residents with falls to assist with identifying appropriate interventions. The newly created falls checklist provides the notification as a reminder to the staff to PT of falls. **3)** On 5/27/12, DON has developed a tracking process to log all accidents and incidents, and investigate in a timely manner. A Falling Leaf Program was implemented in January 2012, revised 5/29/12 which includes PT screens on all falls. Developed new checklist for falls, bruises and skin tear to ensure correct investigation and track appropriate interventions. The Office Manager will maintain a list of new employees with dates of	

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{F 323}	Continued From page 65 Interviews with random facility staff during the revisit confirmed they had received in-services related to Behavior Assessment and Monitoring Program; Incidents and Accidents; Falls Prevention Program (Falling Leaf); Restraint Use and Management; Accident and Incidents Clinical Protocol for Conducting Neuro-Checks (falls with head injury and/or un-witnessed falls); and Hoyer Lift and Transfers. Interview with the Director of Nursing confirmed personal oversight of Incidents and Accidents and the Fall Prevention Program. Continued interview confirmed, to ensure continuity in the facility's compliance, Occurrences and Incidents and Accidents are reviewed daily, Monday thru Friday, during normal work days. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 323}	abuse registry checks. No employee will be able to begin work until registry checks are complete. This will be monitored by the Administrator monthly. 4) The DON will report the outcomes of accident and incident investigations. The Office Manager will report on abuse registry checks to the quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
{F 363} SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation,interview, review of	{F 363}		

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{F 363} SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation,interview, review of	{F 363}	F363 483.35 (c) 1) All menus have been updated with correct portions size/scoop by the dietary manager and signed by dietitian on 5/21/12. 100% of dietary staff have been in-serviced by the dietary manager on these menus and the correct scoop to use when serving each item, substitution of items must be approved with dietary manager prior to	6/6/12

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{F 363}	Continued From page 66 resident council meeting minutes, and review of dietary menus, the facility failed to ensure menus included portion sizes for five of five weeks, failed to ensure planned menus were followed, and failed to ensure mechanically altered menus were consistent with the regular menu for two of two lunch meals observed. The findings included: Observation of the tray line on May 14, 2012, at 9:50 a.m., in the dietary department, revealed the staff serving casserole and potatoes with a green scoop (#6 scoop=2/3 cup), peas and carrots with a slotted serving spoon (unknown quantity), pureed tomatoes and pureed fiber protein with a grey scoop (#8 scoop=1/2 cup). Interview with the Dietary Manager on May 14, 2012, at 10:05 a.m., in the dietary office, revealed the green scoop contained 2 2/3 ounces, the grey scoop contained ½ cup, and the slotted spoon portion size was unknown. Further interview with the Dietary Manager confirmed the menus provided for the last five weeks signed by the Registered Dietician (RD) had no portion sizes. Telephone interview with the RD, on May 14, 2012, at 1:50 p.m., confirmed the menus had been prepared by an outside dietetic company, did not have portion sizes, and current dietary standards for menu preparation were to indicate measured portions. Observation of the tray line on May 15, 2012, at 11:20 a.m., revealed the pureed desert for a diabetic resident was unavailable and was	{F 363}	substitution, items requests by personal menu for those residents receiving them will be provided 5/27/12. 2) Before a menu is posted the Dietary Manager will make sure items on the menu are available and in stock or that they will be ordered on Monday to be delivered on Wednesday. The menu will then be posted by Friday for the following week. This procedure was implemented on 5/27/12 3) Beginning 6/1/12 the Dietary Manager will interview each resident with a Personal Menu once weekly for 4 weeks, then monthly for two months, to make sure they are receiving the items ordered on their Personal Menu. On 6/1/12 The Dietary Manager will conduct quarterly in-services on: Scoop size and portion control and Personal Menu's to include what they are and what choices the resident have and to make sure their choices are delivered at time of request.	

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{F 363}	Continued From page 67 substituted with a regular pureed desert and approved by the Dietary Manager. Review of Resident Council meeting minutes for May 9, 2012, revealed complaints from residents regarding dietary menus not being followed. Interviews with residents in the group meeting on May 14, 2012, at 3:00 p.m., revealed complaints from all five residents present about the facility not following the planned menus. Observation on May 14, 2012, at 11:20 a.m., in the dietary department, revealed the following items were being served for lunch: linkett casserole, mashed potatoes, carrots and peas (substituted for green beans), carrot salad, and pureed tomatoes, and pureed fiber protein. Review of the planned menu for May 14, 2012, signed by the RD revealed: linkett casserole, green beans, bread and butter, cole slaw, frosted pineapple, and cookies. Observation on May 15, 2012, at 11:30 a.m., in the dietary department revealed the following items were served for lunch: chicken tetrazzini (substituted for lentil loaf), collard greens, bread and butter (substituted for mashed potatoes and gravy), and pureed diced tomatoes. Review of the planned menu for May 15, 2012, signed by the RD revealed: lentil loaf, mash potatoes, gravy, collard greens, bread and butter, diced tomatoes, and fruit cocktail cake. Interview with the Dietary Manager on May 15, 2012, at 1:20 p.m., in the dietary department,	{F 363}	Beginning 6/1/12The Dietary Manager will maintain a copy of the weekly menu and will check two meals per week by doing the following: (1) checking five resident trays in the dinning room or resident's room against the menu. (2) looking for any substitutions. Any Substitute menu items will be written on the current menu for tracking the number of substitutions. 4) The dietary manager will report outcomes of monitoring menus and preparations to the Quarterly QA/PI committee and the administrator will report to the board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

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{F 363}	Continued From page 68 confirmed the planned menus were not followed and the pureed diet always consisted of the items which had been served on the regular menu the previous day, and differed from the day's regular menu.	{F 363}		
{F 367} SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide a therapeutic diet for two residents (#23, and #24) of twenty-seven residents reviewed. The findings included: Resident #23 was admitted to the facility with diagnoses including Dementia and Osteoporosis. Medical record review of the Mimimum Data Set (MDS) dated March 15, 2012, revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and on a mechanically altered diet. Medical record review of an Interdisciplinary Care Plan last reviewed on June 16, 2011, revealed, "...assist with feeding as needed...honey thickened liquid 2/7/12..." Medical record review of a Resident Plan of Care	{F 367}		

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{F 367}	Continued From page 69 Instructions, no date, revealed, "...can be fed using a syringe..." Medical record review of a Physician Orders for Scope of Treatment (POST) dated September 11, 2009, revealed "...feeding tube for a defined trial period..." Medical record review of a Physician Recapitulation Orders dated May 2012, revealed, "...Diet - N/A (non applicable) honey thickened liquids..." Medical record review of Mobile Dental Services notes dated March 8, 2011, March 29, 2011, May 18, 2011, September 15, 2011, and January 5, 2012, revealed the resident had been treated. Medical record review of a Nurse's Note dated September 15, 2011, at 1:00 p.m., revealed a care plan meeting by way of telephone with the resident's daughter and no indication the resident was to be fed by a syringe. Medical record review of a Dietary Manager note dated September 15, 2011, at 2:45 p.m., revealed, "...complete feed and at times requires a syringe to feed..." Medical record review of a Dietician note dated September 22, 2011, at 9:33 a.m., revealed, "...fed with syringe as needed..." Medical record review of a Dietician note dated December 28, 2011, at 9:40 a.m., revealed, "...continue POC (plan of care)..." Medical record review of a Dietician note dated	{F 367}	2) On 5/15/12 to 5/16/12, DON/ADON observed all other residents and no other residents were being fed with a syringe. In-service on "Assistance with Meals" were provided to each RN, LPN, & CNA's 5/27/12-5/30/12. Any RN/LPN/CNA who has not attended the above in-service cannot work until they have attended an in-service. 3) The DON/ADON will monitor monthly residents requiring assistance with eating to ensure that no resident is being fed with a syringe without physician order and proper evaluation by Speech Therapist beginning 6/1/2012. 4) The DON will report to the QAPI Committee the outcomes of monitoring residents requiring assistance with eating and any swallowing difficulties. The DON will report the outcomes at the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

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{F 367}	Continued From page 70 March 26, 2012, at 4:13 p.m., revealed, "...honey thick liquids...vegan/pureed...fed with syringe but sometimes won't open mouth..." Observation on May 15, 2012, at 8:05 a.m., in the activity room, revealed Resident #23 sitting in a wheel chair, Certified Nurse Aide (CNA) #16 feeding the resident with a sixty cc (cubic centimeters) syringe. Interview with CNA #16 on May 15, 2012, at 8:10 a.m., revealed the syringe contained pureed oatmeal, peanut butter, and milk. Observation with the Director of Nursing (DON) on May 15, 2012, at 8:18 a.m., in the activity room, revealed CNA student #1 feeding resident #23 with a syringe containing milk that had not been thickened and the DON instructed the student to thicken the milk. Interview with the CNA Instructor on May 15, 2012, at 9:50 a.m., in the front office, confirmed CNA student #1 had not been trained to feed with a syringe. Resident #24 was admitted to the facility on May 1, 2009, with diagnoses including Cardiovascular Accident, Contracture, and Pain. Medical record review of a MDS dated March 22, 2012, revealed the resident was severely impaired for daily decision making, inattention fluctuates, totally dependent on staff for eating, no swallowing disorder, and on a mechanically altered diet. Medical record review of the Interdisciplinary	{F 367}	**Resident #24** 1) Resident #24 was assessed on 5/17/12 by the DON for need to use a syringe for eating her food. DON in-serviced all RNs, LPNs, & CNAs on 5/27/12-5/30/12 concerning use of syringes for residents with out an order from MD or Speech Therapist. Any RN/LPN/CNA who has not attended the above in-service cannot work until they have attended an in-service. Resident #24 was assessed by DON for need of feeding device, family notified, and device d/c'd on 5/17/12. 2) On 5/15/12 to 5/16/12, DON or designee observed all other residents and no other residents were being fed with a syringe. In-service concerning feeding of residents were provided to all RNs, LPNs, & CNAs on 5/27/12-5/30/12. Any RN/LPN/CNA who has not attended the above in-service cannot work until they have attended an in-service. 3) The DON or designee will monitor monthly to ensure that no	

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{F 367}	Continued From page 71 Care Plan dated March 22, 2012, revealed, "...mechanically altered diet...tolerate consistency of food without evidence of choking...pureed diet texture...offer small bites...remind to swallow...monitor for S/SX (signs and symptoms) aspiration...use a sippy cup for all liquids..." Medical record review of a Physician Recapitulation Orders dated May 2012, revealed, "...Diet Pureed...honey thickened liquids..." Medical record review of a Physician Orders for Scope of Treatment (POST) dated May 1, 2009, revealed, "...no feeding tube..." Medical record review of a Dietary note dated March 22, 2012, at 11:43 a.m., revealed, "...some days...confused and won't eat at all or very little..." Medical record review of a Dietitian note dated March 26, 2012, at 8:54 a.m., revealed, "...takes a while to swallow...receiving honey thick liquids..." Observation on May 15, 2012, at 11:30 a.m., in the resident's room, revealed CNA #16 feeding the resident with a 60 cc syringe and a straw for water. Interview with CNA #16 on May 15, 2012, at 11:45 a.m., in the resident's room, revealed the CNA gave the resident water not thickened, and places water in the resident's pureed food so it would go through the syringe. Interview with the DON on May 15, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to obtain a Physician's Order, assess,	{F 367}	resident will be fed with a syringe without physician order and proper evaluation by Speech Therapist beginning 6/1/2012. This will continue monthly for 6 months until substantial compliance is obtained. 4) The DON will report the outcomes of monitoring residents requiring assistance with eating and any swallowing difficulties at the next quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee is 6/20/12.	

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{F 367}	Continued From page 72 screen or evaluate, or care plan intervention for syringe feeding residents #23 and #24. Continued interview at this time confirmed the Medical Director had not addressed feeding tubes with resident #23 and #24's families; and the therapeutic diet was altered by thinning resident #23's diet with thin milk and resident #24's diet with thin water.	{F 367}		
{F 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide sanitary conditions in the food preparation and food storage areas of the dietary department. The findings included: Observation of the dietary department on May 14, 2012, from 9:50 a.m. until 10:15 a.m., revealed in a cabinet over the prep table were two open boxes of vanilla wafers and graham crackers, unsealed and undated, the shelf was dirty with debris, and tiles were missing on the backsplash of the prep table. Further observation revealed a	{F 371}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 367}	Continued From page 72 screen or evaluate, or care plan intervention for syringe feeding residents #23 and #24. Continued interview at this time confirmed the Medical Director had not addressed feeding tubes with resident #23 and #24's families; and the therapeutic diet was altered by thinning resident #23's diet with thin milk and resident #24's diet with thin water.	{F 367}		
{F 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide sanitary conditions in the food preparation and food storage areas of the dietary department. The findings included: Observation of the dietary department on May 14, 2012, from 9:50 a.m. until 10:15 a.m., revealed in a cabinet over the prep table were two open boxes of vanilla wafers and graham crackers, unsealed and undated, the shelf was dirty with debris, and tiles were missing on the backsplash of the prep table. Further observation revealed a	{F 371}	F371 483.35(i) Food Procure, Store/Prepare/Serve-Sanitary 1) On 5/28/12 the following items were cleaned and/or fixed by the kitchen staff. • Juicer, microwave plate, two ovens and backsplash have been cleaned. • The air conditioner has been cleaned. • 6-door refrigerator doors have been cleaned and trim fixed. • Replaced stainless steel containers with plastic storage containers. Food items: • Vanilla wafers, graham crackers were placed in ziplock bags and dated. • Personal food item removed	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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		F 371	**2)** On 5/31/12 the Dietary Manager in-serviced 100% of the dietary staff on the following: • All opened food items must be placed in sealed container and dated. • Supervisor to check all items for cleanliness at the end of the shift prior to dietary staff leaving for the day. • Cleaning of air conditioner has been added to weekly list on Wednesday and in-serviced. • Cleaning schedule and assignments have been in-serviced. • In-serviced that no personal items to be stored in kitchen refrigerators and all items need dating when placed in any refrigerator in the facility. **3)** On 5/31/12 Dietary Manager in-serviced "Daily Check List" with supervisors. On 5/31/12 the following process was began, the Dietary Manager will review "Daily Check List's " on a weekly basis and will do a weekly walk thru rounds checking each item on this list.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 371}	Continued From page 73 juicer with dried food debris on the shaft, a mixer with dried food debris, the microwave plate had dried food debris and the microwave table was dirty, the two ovens had food buildup inside, and the backsplash behind the burners had build up of black debris. Observation in the food preparation area revealed a window unit air conditioner with a dusty grill blowing in the food preparation area. Observation of the reach in cooler revealed six of six doors had mold on the door seals, the bottom center compartment had a trim piece missing, and one staff had personal food items stored in the cooler, undated. Observation of the dry storage area revealed seventeen stainless steel containers with a black sticky build up on the exterior of the canisters. Interview with the Dietary Manager on May 14, 2012, from 10:05 a.m. until 10:10 a.m., in the dietary department, confirmed open food items were to be sealed and dated, the dietary equipment and air conditioner was in need of cleaning, the reach in refrigerator seals needed replacing, and staff food was not to be stored in the resident refrigerator.	{F 371}	4) The Dietary Manager will report outcomes to the QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
{F 406} SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	{F 406}		

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{F 406} SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	{F 406}	**F 406 483.45 (a) Provides /Obtain Specialized Rehab Services** 1) Resident #5 Discharged from facility on 2/5/11. On 5/27/12 the DON revised and developed new Behavior Assessment and Monitoring Policies	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 406}	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on facilty investigation review, medical record review, and interview, the facility failed to obtain and/or provide specialized mental health rehabilitation services for one resident (#5) of twenty-seven residents reviewed. The facility's failure placed resident #4 in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The facility provided a Credible Allegation of Compliance on May 30, 2012. A revisit conducted on June 4 - June 5, 2012, revealed the corrective actions implemented on May 30, 2012, removed the Immediate Jeopardy. Non-compliance for F-406 continues at a "D" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff, including administrative staff. The facility provided evidence Resident #5 was discharged from the facility on February 5, 2011. The facility provided evidence of in-services	{F 406}	to address residents identified as having problematic behaviors that would need psychiatric consultation and behavioral management. These policies include Behavior Assessment and Monitoring, use of Restraints, and Unmanageable Residents. Residents admitted with a history of impaired cognition, problematic behaviors, or mental illness will have a Geropsych Practitioner Consult (noted in policy). Policies were approved by Medical Director and QA Committee on 5/27/12. Exhibit # 19 Exhibit # 10 In-services were conducted on revised Behavior Management Policies and Guidelines for Notification of Physician for Problematic Behaviors and other issues conducted by RN/BSN. RN, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 406}	Continued From page 75 related to policies and procedures for Abuse, to include: Reporting Abuse/Alleged Abuse to Facility Management; Resident-to-Resident Altercations; Abuse Investigations; and Behavior Assessment and Monitoring Program. The Medical Director evaluated all Residents with psychoactive medications and Residents with behavioral diagnoses; and the Geriopsych provider consulted with Residents with a history of impaired cognition, behavioral episodes, and/or mental illness. The Director of Nursing, Assistant Director of Nursing, and the Minimum Data Set Coordinator assessed all remaining Residents to ensure appropriate services were being provided. The facility provided evidence of a Psych Services Provider contract specifying every other week psych visits to address Residents with impaired cognition, behavioral episodes, and/or mental illness. The facility provided evidence of care plan reviews to ensure appropriate behavioral interventions and services. Observation of the Residents throughout the follow-up visit revealed facility staff approached and interacted appropriately with the Residents, according to the facility's Behavioral Management Program. Continued observation of random Residents revealed no Resident altercations or behavioral episodes. The facility environment was calm and staff was actively engaged with behavioral and wandering Residents. Interviews with random facility staff during the revisit confirmed they had received in-services	{F 406}	are complete. DON/RN will oversee inservices and report to QA/PI. The Administrator and the DON reviewed the Gerio psych contract to ensure every other week visits could be provided timely to address residents with impaired cognition, problematic behaviors or mental illness. This was confirmed on 5/18/12 by the Administrator. Resident #4 The Abuse Investigation policies ie; Reporting Abuse to Facility Management; Resident to Resident Altercation; Abuse Investigations; Behavior Assessment and Monitoring have been reviewed and revised on 5/27/2012 by the DON and approved by the Medical Director, Administrator and QA Committee on 5/27/12. Inservices conducted 5/27/12-5/30/12, for all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 406	complete. DON/RN will oversee inservices and report to QA/PI. Exhibit #24 The Abuse Investigation policy was inserviced with the Administrator, DON and Medical Director on 5/27/12 by the Healthcare Consultant emphasizing the importance of recording abuse allegation, investigating and reporting in a timely manner. **2)** The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on –Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior Management. The following policies or procedures have been changed to address this deficiency practice: -Use of Restraints	

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		F 406	-Behavior Assessment and Monitoring -Side rail Evaluation on Admission and Quarterly -Abuse Investigation -Resident Rights – guidelines for all Nursing Procedures Inservices were conducted 5/27/12-5/30/12 for all RN, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 10 Teachable moments/in-services were conducted by DON on 5/24 and 5/25/12 on the following topics: -Resident Rights and Dignity -Restraints i.e. Seclusion -Abuse/Seclusion for Resident #1 -Accident and Supervision -Behavior Management	

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		F 406	Inservices were conducted 5/27/12-5/30/12 for all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 11 On 5/27/12 the Medical Director made rounds, assessed and evaluated all residents with psychoactive medications or residents with behavior diagnoses. This evaluation was also documented in the Medical Record on 5/27/12. DON/ADON/MDS Coordinator assessed all other residents to ensure appropriate services were being provided. There were no residents observed needing additional services. This process began on 5/15/2012, completed on 5/27/12. The care plans were reviewed and revised by MDS Coordinator to include appropriate services. This	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 406	process began on 5/15/2012, completed on 5/29/12. MDS Coordinator reviewed all other residents care plans to ensure appropriate services were care planned. This process started 5/15/12, completed 5/29/12. **3)** The DON/ADON/RN Staff will monitor behaviors weekly as documented in Accu Care under "behaviors" to identify any needed consultation services. A list of residents seen by Geriopysch Services will be provided to the DON to monitor services provided. 6/1/12, a template was developed by the ADON for electronic medical record system for weekly behavior assessment. **4)** The DON will report the outcomes of abuse and behavior management monitoring to the quarterly QAPI Committee and ultimately the Administrator will report to the Board quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

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{F 406}	Continued From page 76 related to Abuse, to include: Reporting Abuse/Alleged Abuse to Facility Management; Resident-to-Resident Altercations; Abuse Investigations; and Behavior Assessment and Monitoring Program. The facility will remain out of compliance at a "D" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 406}		
{F 428} SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician timely of pharmacy consultant reports for two residents (#1, and #12) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia,	{F 428}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 428}	Continued From page 77 Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of a Pharmacy Consultation Report dated September 1, 2011, revealed, "...please recheck BMP (Basic Metabolic Profile lab work) to monitor K+ (potassium) frequent changes in Lasix (diuretic)..." Continued review of the Pharmacy Consultation Report revealed the Physician was not notified until February 29, 2012 (181 day delay). Medical record review of a Pharmacy Consultation Report dated March 6, 2012, revealed, "...please consider change 4pm-5pm doses of Baclofen (muscle relaxant) 20 mg, (milligram) ibuprofen (antiinflammatory) 600 mg, and oxybutynin (anticholinergic) to prn (as needed) DC (discontinue) the 10 pm dose of Miralax (constipation) change carbamazepine (anticonvulsant) to hs (hour of sleep)..." Continued review revealed the Physician had not been notified of the report on May 15, 2012, (a sixty-four day delay). Resident #12 was admitted to the facility on March 29, 2012, with diagnoses including Contusion to Knee, Diabetes Mellitus, and Fibromyalgia. Medical record review of a Pharmacy Consultation Report dated April 2, 2012, revealed "...omeprazole (for reflux) 40 mg qd (every day)...consider decrease to 20 mg..." Continued review of the Pharmacy Consultation Report revealed the Physician did not respond until April 25, 2012.	{F 428}	Pharmacy consultant for the past 6 months. This was completed 6/1/12. Any recommendations consisting of medication changes will be called to the physician for action and all other recommendation will be reviewed at next visit. 3) The ADON will maintain the notebook for pharmacy reviews and will make it accessible for physician review and signature. Each resident review will be initialed by physician & dated. 4) The DON will report outcomes of Pharmacy Reviews to the quarterly QAPI Committee beginning with meeting in 6/1/12 and ultimately the Administrator will report to the Board Meeting quarterly. The next QAPI Committee meeting is 6/20/12.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
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OMB NO. 0938-0391

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{F 428}	Continued From page 78 Medical record review of a Pharmacy Consultation Report dated May 1, 2012, revealed "...assess possible need for increase in pain meds(medications)...receives frequent..." Continued review of the Pharmacy Consultation Report revealed the doctor had not been notified of the report as of May 15, 2012 (a fourteen day delay). Interview with the Director of Nursing (DON) on May 15, 2012, at 9:10 a.m., in the front lobby, confirmed the facility failed to notify the physician of the pharmacy recommendations in a timely manner. C/O #27265 #28092	{F 428}		
{F 431} SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	{F 431}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 428}	Continued From page 78 Medical record review of a Pharmacy Consultation Report dated May 1, 2012, revealed "...assess possible need for increase in pain meds(medications)...receives frequent..." Continued review of the Pharmacy Consultation Report revealed the doctor had not been notified of the report as of May 15, 2012 (a fourteen day delay). Interview with the Director of Nursing (DON) on May 15, 2012, at 9:10 a.m., in the front lobby, confirmed the facility failed to notify the physician of the pharmacy recommendations in a timely manner.	{F 428}		
{F 431} SS=F	C/O #27265 #28092 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	{F 431}	**F 431 483.60(b), (d), Drug Records, Labels/Store Drugs and Biologicals** 1) Upon being made aware of LPN #4, and RN #1's deficient practice of not ensuring that medications were being properly labeled, multi-dose vials labeled incorrectly, and failure to separate internal and external medications in medication carts, inservices were conducted by DON to LPN's #4, #2 and RN #1 on 5/15/12 on the policy of "Administration of Medications" and " Medication Family Supplied". This included labeling of multi-dose	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 431}	Continued From page 79 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure medications were labeled for two of two medication carts observed and failed to separate internal and external medications for one of two medication carts. The findings included: Observation of medication cart #1 at the nurse's station on May 15, 2012, at 1:00 p.m., revealed one vial of Levemir (long-acting insulin) 100 u/ml (units per milliliter), 10 ml vial, with no date opened documented on the vial. Further observation revealed a sticker placed on the vial with a "discard date of 6/28," 45 days from the day of the observation on May 15, 2012. Review of the manufacturer's recommendations revealed, "Keep at room temperature...for up to 42 days." Continued observation of medication cart #1	{F 431}	vials, and storage of internal and external medications and labeling all drugs in the medication cart. On 5/2812 and 5/29/12 DON conducted an in-service on "Administration of Medication", and "Medication, Family Supplied" to RN's and LPN's. Any RN, or LPN who have not attended the above in-services will not be allowed to work until they have attended the above mentioned in-services. Exhibit # 47 2) On 5/29/12, DON/ADON checked medication carts to ensure proper labeling of multi-dosed vials, separation of internal and external medications, checked for unlabeled medications on the carts, and identified other residents having the potential to be affected by the same deficient practice. 3) Medication Pass and medication cart checks will be observed by the ADON or designee beginning 6/1/12 to ensure that the facility policy and state laws are observed including physician orders for all medications, appropriate labeling of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 431}	Continued From page 80 revealed a vial of Fluphenazine decanoate (long-acting antipsychotic) 25 mg/ml (milligrams per milliliter), 5 ml vial with no documentation of date opened or a discard date. Interview with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #4 on May 15, 2012 at 2:15 p.m., at the nurse's station, confirmed the vials of medication did not accurately reflect expiration dates. Continued interview with LPN #4 on May 15, 2012, at 2:45 p.m., in the hallway, revealed the Fluphenazine decanoate expired 28 days after opening. Observation of medication cart #2 on May 15, 2012, at 2:30 p.m., revealed, in the bottom drawer, five ziplock bags labeled with the names of herbal medications and no resident name or date. Interview with LPN #2, on May 15, 2012, at 2:30 p.m., at the nursing station, confirmed the 5 five ziplock bags of capsules containing Dandelion Leaf, Hawthorne Berry, Tumeric, Bilberry Leaf, and Vitamin C, had no original containers, no label, no manufacturer instructions, no record of pharmacy review, no dosage instructions and no expiration date. Observation of medication cart #2 on May 15, 2012, at 2:30pm, at the nursing station, revealed oral medications including Tylenol (pain reliever), Benadryl (antihistamine), and Vitamin C (vitamin), were stored with external medications, including Nystatin Cream (anti-fungal) 100,000 u/GM (gram) 30 GM tube, three tubes of Triple Antibiotic Ointment Cream 1 oz (ounce), and Pain Relieving Cream 4 oz tube. Betadine	{F 431}	multi-dose vials, correct labeling of herbal medications, and correct storage of internal and external medications. The Pharmacy consultant will assist in Med Pass observations of RNs & LPNs administering medications within the facility beginning 6/1/12. The DON/ADON/ RN Staff will monitor medication administration to ensure resident medications have physician orders, correctly labeled multi-dose vials, and ensure correct storage of internal and external medications. This was begun on 5/15/12 and will continue weekly for 4 weeks then monthly on a random basis to ensure compliance has been achieved. 4) The DON will report the outcomes of medication monitoring to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee is 6/20/12.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{F 431}	Continued From page 81 (anti-bacterial cleanser), sunscreen, Kionex (medication to lower potassium), Johnson's Baby Shampoo, insulin syringes, Vitamin C and multiple bottles of oral medications were stored together in the same drawer. Review of facility policy Family Supplied Medication revealed, "...The facility will also use medications purchased for a resident from a dispensing pharmacy...if the following conditions are met...The medication name, dosage form, and strength have been verified by the nurse accepting the medication...the medication container is clearly labeled in accordance with pharmacy procedures for medication labeling and packaged in manner consistent with pharmacy guidelines for medications...including the resident's name, specific directions for use, including route of administration, medication name, strength of medication, physician's name, date medication is dispensed, quantity, expiration date...Herbal supplements are used by our resident's in accordance with the above procedures. They must be kept in original containers with expiration date clearly visible..." Interview with LPN #2, on May 15, 2012, at 2:30 p.m., at the nursing station, confirmed internal and external medications were to be stored separately and were not properly labeled.	{F 431}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	{F 441}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	{F 441}	**F 441 483.65 Infection Control, Prevent Spread, Linens** 1) Upon being made aware of deficiency, the housekeeping supervisor cleaned the overflow room of debris and soiled linen on	6/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 441}	Continued From page 82 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of manufacturer's instructions, the facility failed to ensure clean linen was stored in a sanitary manner in the overflow linen closet; failed to	{F 441}	5/18/12. Housekeeping supervisor reviewed policy on 5/18/12 and revised process for the proper storage of clean linen placed in the overflow room. 2) Housekeeping supervisor checked all linen storage areas for debris and soiled linen on 5/20/12. In-service completed on 5/28/12 of the proper process of linen storage and the need to be covered with clean linen and put on a weekly check list with housekeeping staff. 3) Overflow room will be checked weekly by housekeeping supervisor for compliance beginning 5/21/12. 4) The housekeeping supervisor will report outcomes of checks to the quarterly QA/PI committee and ultimately the administrator will report to the board meeting quarterly. The next scheduled QAPI Committee meeting is 6/20/12. LPN #4 1) Upon being made aware of LPN #4's deficient practice of administering medication without	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 441}	Continued From page 83 perform hand hygiene during medication pass for one Licensed Practical Nurse (LPN # 4) of five LPNs observed; and failed to follow manufacturer's recommendations to provide sanitary medication administration for one of two medication carts. The findings included: Observation of an overflow linen storage room on May 14, 2012, at 11:20 a.m., revealed clean linen was stored below cobwebs, debris was on the ceiling and walls, and clean sheets stored in the room had debris on them. Interview with the Laundry Manager on May 14, 2012, at 11:20 a.m., at the doorway of the overflow linen storage room, confirmed debris had fallen onto the clean linen and the linen was not stored in a sanitary manner. Observation of a medication pass on May 15, 2012, at 7:50 a.m., in a resident's room revealed LPN#4 administered medication to a resident, washed the hands, touched the resident's food and tray items, and without washing the hands, exited the room, dispensed medications for resident #14, and entered the resident's room and administered medications. Interview with LPN #4 on May 15, 2012, at 7:50 a.m., in the hallway, confirmed the LPN failed to wash the hands after assisting one resident with a meal and prior to preparing the next resident's medication. Observation of medication cart #2, on May 15, 2012, at 2:30 p.m., at the nursing station,	{F 441}	washing hands, the DON in-serviced LPN #4 on hand washing procedures while administering medications on 5/15/12. All other RN's LPN's and CNA's were in-serviced on hand washing policy on 5/27-5/29/12. Any RNs, CNAs or LPNs who have not attended the above in-services will not be allowed to work until they have attended the above mentioned inservices. 2) The DON or RN staff nurse observed a random sampling of direct care staff, (LPNs, RNs and CNA) for proper hand washing during the week of 5/25-5/31/12. 3) All nurses will be checked quarterly by DON or designee on proper hand washing. The DON or designee will monitor proper hand washing randomly. This was begun on 6/1/12 and will continue as needed to ensure compliance has been achieved. 4) The DON will report the outcomes of hand-washing in-services to the next quarterly QAPI Committee and ultimately the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 441	Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting on 6/20/12. **LPN #2** **1)** Upon being made aware of LPN #2's deficient practice of re-use of syringe for liquid medication, in-service was done by the DON on 5/18/12 to LPN #2 per the "Administration of Medication Policy", noting that Leur-lock Syringes are for single use only. After administrating of medication, syringe should be discarded. The DON or designee will observe LPN #2 weekly for four weeks for proper administration of liquid medications with a leur-lock syringe. **2)** On 5/15/12 to 5/29/12 ADON randomly observed medication administration on four nurses which included liquid medications via a syringe. On 6/1/12 the DON in-serviced all other licensed staff on the deficient practice observed by surveyors. The in-service consisted	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 441	of the need to dispose of syringes after each use. **3)** Medication Pass will be observed by the DON or designee on a monthly basis beginning 6/1/12 to ensure that the facility policy and state laws are observed concerning single use of syringes. The Pharmacy consultant will assist in monthly Med Pass observations of RNs & LPNs during administration of medications within the facility beginning 6/1/12. **4)** The DON or designee will monitor proper liquid medication administration via a syringe randomly. This was begun on 6/1/12 and will continue as needed to ensure compliance has been achieved. The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting on 6/20/12.	

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{F 441}	Continued From page 84 revealed an opened 30 cc (cubic centimeter) syringe with pink liquid in and on the syringe, stored in the bottom right drawer with liquid medications. Observation of the label revealed "30 cc leur-lock Single-Use Syringe ...DO NOT REUSE ..." Interview with LPN #2 on May 15, 2012, at 2:30 p.m., at the nursing station, confirmed the syringe was soiled with a pink liquid and was re-used multiple times to dispense one resident's liquid medication.	{F 441}		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, observation, and interview, the facility failed to be administered in a manner to ensure four (#1, #2, #3, #11) residents were free from abuse, failed to investigate allegations of abuse, failed to provide staff in-services on abuse, failed to provide supervision to ensure twelve (#14, #3, #2, #4, #5, #19, #26, #1, #12) residents were provided a safe environment, and failed to ensure one resident was provided mental health services (#5) of twenty-seven residents reviewed. The facility's failure placed the residents in Immediate Jeopardy. (Immediate Jeopardy is a situation in which a provider's noncompliance with one or	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	Continued From page 85 more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on May 30, 2012. A revisit conducted from June 4 - June 5, 2012, revealed the corrective actions implemented on May 30, 2012, removed the Immediate Jeopardy. Non compliance for F-490 continues at an "F" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff including administrative staff. The facility provided evidence an independent, Healthcare Consultant, had been retained to assist the facility in systems management to improve the quality of care for the residents, and provide staff education in areas deemed lacking. The Healthcare Consultant was introduced to the survey team on June 5, 2012, at 8:30 a.m., in the therapy room. Medical record review revealed resident's with behaviors, safety concerns, and special needs, were identified, appropriately care planned, and physician's order obtained for services. The facility provided evidence of the review and revision of the facility's Abuse Prevention Program, approved by the Medical Director at the Quality Assurance meeting conducted on May 29,	F 490	On 5/26/12 the Administrator confirmed the contract agreement with Healthcare Consultant to assist with addressing compliance of the deficiencies sited on May 14 and 15 by the Health Surveyors. On 05/28/12 the Abuse Investigation / Incident and Accident/ Investigating and Reporting Policy / Restraint Management Policy was reviewed and revised by the Health Care Consultant . The Health Care Consultant inserviced these policies with the DON, Administrator and Medical Director emphasizing the importance of elimination of the use of seclusion, reporting abuse, investigation, using the Resident Abuse Investigation Report Form, timely investigations and capturing all incidents. Exhibit #29 The DON implemented a Behavior Assessment and Monitoring Program which includes a consultation with Geriopsych Practitioner when needed by residents. Effective following	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 490	approval by the Medical Director and QA Committee on 5/27/2012. Exhibit #6 All residents admitted to the facility will have a Social Services Assessment / History according to facility policy. Exhibit #7 The facility will maintain 100% compliance of checking abuse registry on all new employees will be completed. Exhibit # 30 DON will conduct mandatory in-services at least twice a year to ensure an opportunity for employee attendance. Effective 5/29/2012. DON implemented a new Side Rail Assessment to be conducted on all new admissions and Quarterly thereafter. A Falls Prevention Program called The Falling Leaf Program was developed by the interdisciplinary team in January 2012 and Physical Therapy is responsible for this	

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		F 490	program. This has been reviewed and revised on 5/27/12 to provide staff and interdisciplinary team members with an approach to evaluating and identifying appropriate interventions. The Falls Prevention Program includes a quarterly assessment of resident rooms and bath equipment conducted by maintenance staff for needed repairs. This assessment was begun January 2012 and revised 05/29/2012 to capture the appropriate documentation for repairs. Beginning 5/22/12 the Physical Therapist began screening residents with falls. Use of Restraint policy was developed by DON and approved by Medical Director and QA Committee 5/27/12. No restraints can be applied without approval of DON/ Medical Director. Exhibit # 10 After being informed by surveyor that CNA #12 had transported Resident #21 down the hallway	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 490	from shower room, in a Hoyer Lift, the DON conducted a teachable moment with CNA #12 and other staff working that day teaching that residents must not be transported in the hallway when residents are in the Hoyer lift. The Hoyer lift policy was reviewed with all staff working on the 6-2pm and 2-10pm shifts by the DON. Inservices were then given to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI **2)** The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. In-services were conducted 5/15, 5/24, 5/27, 5/28 and 5/29 on –Abuse Investigations, Residents Rights, Restraints, Safety, Fall Investigation, Care of residents with Seizures, and Behavior Management. Inservices were then	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 490	given to all RN's, LPN's, CNA's, by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. President of Laurelbrook School, will oversee Laurelbrook Nursing Home Administrator to ensure compliance and that the quality of care will be provided. Effective 5/29/2012. **3)** The DON or designee will monitor all behaviors weekly to ensure residents receive appropriate care and biweekly by Geriopysch Services, who will provide DON a list of all residents seen at each visit. Restraints will be monitored weekly for four weeks until process is in place and functioning efficiently, then quarterly thereafter. Abuse allegations will be logged as received and investigated 24-72 hours, effective 5/15/2012. The DON/MDS Coordinator/PT will monitor all falls. An accident and incident log was created to insure timely investigations. New	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	Continued From page 86 2012. Continued review of the evidence revealed the revised program contained detailed information on Resident-to-Resident Altercations, Abuse Investigations, Reporting Abuse to Facility Management, and a 3-page investigative worksheet for data gathering and evaluation titled, Resident Abuse Investigation Report Form. The facility provided evidence of mandatory in-service education and training to all staff on Abuse Prevention, Resident Safety, Resident Rights, and Behavior Management. Random interviews with multidisciplinary staff conducted during the revisit from June 4 through June 5, 2012, confirmed they had received in-services related to abuse prevention, resident safety, resident behavior, and resident rights. The facility provided evidence of abuse registry and criminal background checks were completed for the last six employees hired. The facility will remain out of compliance at an "F" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur, and the facility's corrective measure would be reviewed and evaluated by the Quality Assurance Committee.	F 490	forms were created to aid in capturing the appropriate information during investigations. The DON/designee will monitor all restraints assessed and ordered by physician to ensure that all residents are safe by utilizing the least restrictive measures possible. This will be monitored for three months and reevaluate at that time if monitoring needs to continue with approval from the QAPI Committee. The DON/designee will monitor all residents to ensure the absence of all forms of abuse, including involuntary seclusion. This was begun on 5/29/12 and will continue indefinitely to ensure compliance has been achieved. 4) The DON will report the outcomes of abuse, behavior management, and restraint monitoring to the quarterly QAPI Committee and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting on 6/20/12.	
{F 497} SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be	{F 497}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		F 497	received at least 12 hours of in-services per year, the DON/ADON/RN Staff conducted mandatory in-services. The DON will conduct mandatory inservices for RN's, LPN's, and CNA's biannually and non-mandatory in-services quarterly beginning 6/1/12. CNA's will have a printed copy of their hours given to them quarterly so they are aware of their hours to be completed. They will be required to attend 80% of scheduled in-services to ensure their required hours are met. **2)** All CNA's in-service records were reviewed to identify which employees had not received their required 12 hours of in-service in 2011. All CNAs who did not have the required 12 hours of in-service hours received an oral warning for failure to meet employment criteria by DON on 5/29/12. **3)** The DON/Office Manager will monitor on a quarterly basis CNA in-service hours. All CNA's will be expected to fulfill state requirements. An updated list of	

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{F 497}	Continued From page 87 sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation review and interview, the facility failed to provide twelve hours of in-service education per year for six of twenty-two Certified Nurse Aides (CNA) employed. The findings included: Review of facility documentation titled Currently Employed Staff revealed twenty-two CNA's employed by the facility. Review of facility documentation of total in-service hours for January 2011 through December 2011 revealed six of twenty-two listed did not have the twelve hours of the required in-service education. Interview with the Director of Nursing on May 15, 2012, at 3:15 p.m., in the front office, confirmed the facility failed to provide twelve hours of in-service education for the Certified Nurse Aides employed.	{F 497}	CNA's inservices was printed and provided to each CNA on 6/1/12 by the office manager. 4) The DON/Office Manager will report in-service hours of CNAs quarterly to the QAPI Committee beginning 6/1/12 and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting on 6/20/12.	
{F 498} SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able	{F 498}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 498} SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able	{F 498}	F498 483.75(f) Nurse Aide Demonstrate Competency/Care Needs	6/6/12

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{F 498}	Continued From page 88 to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure Certified Nurse Assistant Students were trained to provide services to one resident (#23) of twenty-seven residents reviewed. The findings included: Resident #23 was admitted to the facility on October 2, 2008, with diagnoses including Dementia and Osteoporosis. Medical record review of the Minimum Data Set dated March 15, 2012, revealed the resident was severely impaired for daily decision making, inattention continuously present, totally dependent on staff for eating, no swallowing disorder, obvious or likely cavity or broken natural teeth, and a mechanically altered diet. Medical record review of an Interdisciplinary Care Plan dated last reviewed June 16, 2011, revealed, "...assist with feeding as needed...honey thickened liquid 2/7/12..." Medical record review of a Resident Plan of Care Instructions no date revealed, "...can be fed using a syringe..." Observation with the Director of Nursing (DON)	{F 498}	**Resident #23** 1) Upon being made aware of CNA #16 practice of feeding Resident #23, the DON in-serviced her, and other CNA's, on 5/14/12 concerning the discontinuation of syringe feeding practice without a physician order and how to properly thicken residents food. Use of feeding devices such as use of syringes must be approved by DON prior to using special devices. This was added to the policy "Assistance with Meals" and in-services were provided to all RNs, LPNs, & CNAs on 5/27/12-5/30/12 by DON. Any RN/LPN/CNA who has not attended the above in-service cannot work until they have attended an in-service. Exhibit # 46 2) On 5/15/12 to 5/16/12, DON or designee observed all other residents and no other residents were being fed with a syringe. In-services were provided to each RN, LPN, & CNA's 5/27/12-5/30/12. Any RN/LPN/CNA who has not attended the above in-service cannot	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	R 06/05/2012

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		F 498	work until they have attended an in-service. 3) The DON or designee will monitor monthly residents requiring assistance with eating to ensure that no resident is being fed with a syringe without physician order and proper evaluation by Speech Therapist beginning 6/1/2012. The DON/ADON will monitor residents requiring assistance with eating and any swallowing difficulties and will continue monthly for 6 months or until substantial compliance has been has been achieved. 4) The DON will report the outcomes of monitoring residents requiring feeding assistance at the next quarterly QAPI Committee. and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting is scheduled for 6/20/12.	

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{F 498}	Continued From page 89 on May 15, 2012, at 8:18 a.m., in the activity room, revealed CNA student #1 feeding Resident #23 with a syringe containing milk that had not been thickened and the DON instructed the student to thicken the milk. Interview with the CNA Instructor on May 15, 2012, at 9:50 a.m., in the front office, confirmed CNA student #1 had not been trained to feed with a syringe.	{F 498}		
{F 500} SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on review of facility contracts, the facility failed to provide a dialysis contract. The findings included:	{F 500}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 500} SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on review of facility contracts, the facility failed to provide a dialysis contract. The findings included:	{F 500}	**F 500 483.75(h) Outside Professional Resources-Arrange/Agreement** 1) Upon becoming aware of the need of a dialysis contract, the Administrator completed an agreement for dialysis' services on 5/15/2012. 2) The Administrator reviewed all contracts to ensure all patient contracts were current & viable. 3) The Administrator will review all contracts for validity on a quarterly basis, effective 6/1/12. 4) The Administrator will report quarterly to the QAPI Committee the renewed or additions to	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(F 500)	Continued From page 90 Review of the facility contracts on May 15, 2012, revealed no dialysis contract. Review of a dialysis contract received by fax from the facility on May 16, 2012, revealed the agreement was dated May 15, 2012.	(F 500)	Contracts, and ultimately to the Board meeting quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety, ensure residents were free from abuse, and ensure that residents with mental illness/behaviors were provided psychiatric services. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed resident's #2, #4, #5, #14, #18, #19, and # 26 in Immediate Jeopardy; placed resident #1, #2, and #4 in Immediate Jeopardy related to abuse, and placed resident #5 in Immediate Jeopardy for failure to provide mental health services. (Immediate Jeopardy is a situation in which a	F 501		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 500}	Continued From page 90 Review of the facility contracts on May 15, 2012, revealed no dialysis contract. Review of a dialysis contract received by fax from the facility on May 16, 2012, revealed the agreement was dated May 15, 2012.	{F 500}		
F 501 SS=F	483.75(l) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety, ensure residents were free from abuse, and ensure that residents with mental illness/behaviors were provided psychiatric services. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed resident's #2, #4, #5, #14, #18, #19, and # 26 in Immediate Jeopardy; placed resident #1, #2, and #4 in Immediate Jeopardy related to abuse, and placed resident #5 in Immediate Jeopardy for failure to provide mental health services. (Immediate Jeopardy is a situation in which a	F 501	**F 501 483.75 (2) Responsibilities of Medical Director** 1) Upon receipt of the 2567 Deficiency Report on 5/21/12 identifying immediate jeopardy for F 501 tag, the Medical Director was notified by the DON and the full Survey report was reviewed in-depth with Medical Director on 5/27/12. The Abuse Investigation policies, i.e. Reporting Abuse To Facility Management; Resident To Resident Altercation; Abuse Investigations; Behavior Assessment and Monitoring have been reviewed and revised on 5/27/2012 by the DON and approved by the Medical Director, Administrator and QA Committee on 5/27/12. Exhibit # 24	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 501	Continued From page 91 provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious harm, injury, impairment or death). The facility provided a Credible Allegation of Compliance on May 30, 2012. A revisit conducted on June 4 - 5, 2012, revealed the corrective actions implemented on May 30, 2012, removed the Immediate Jeopardy, Non-compliance continues at an "F" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff including the administrative staff. The facility provided evidence an Independent, Healthcare Consultant, had been retained to assist the facility in systems management to improve the quality of care for the residents, and provide staff education in areas deemed lacking. The Healthcare Consultant was introduced to the survey team on June 5, 2012, at 8:30 a.m., in the therapy room. The facility provided evidence the Medical Director was educated by the Healthcare Consultant/RN on the importance of recording abuse allegations, and investigating and reporting allegations in a timely manner. The facility provided evidence of the review and revision of the facility's Abuse Prevention	F 501	The Abuse Investigation policy was inserviced with the Administrator, DON and Medical Director on 5/27/12 by the Healthcare Consultant emphasizing the importance of recording abuse allegation, investigating and reporting in a timely manner. The DON implemented a Behavior Management and Monitoring Program effective following approval by the Medical Director on 5/27/12 and QA Committee. All residents admitted with a history of impaired cognition, problematic behavior, or mental illness will have a consultation with a Geropsych Practitioner. This was addressed in the revised Behavior Assessment and Monitoring policy. This policy was reviewed and approved by the Medical Director and QA Committee on 5/27/12. Exhibit # 10 On 5/27/12 the DON revised and developed new Behavior Management and Monitoring Policies to address residents identified as having problematic	

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F 501	Continued From page 92 Program, approved by the Medical Director at the Quality Assurance meeting conducted on May 29, 2012. Continued review of the evidence revealed the revised program contained detailed information on Resident-to-Resident Altercations, Abuse Investigations, Reporting Abuse to Facility Management, and a 3-page investigative worksheet for data gathering and evaluation titled, Resident Abuse Investigation Report Form. The facility provided evidence the Medical Director reviewed, revised, and approved the following facility policies on May 27, and May 29, 2012. Abuse Investigation/Seclusion, Behavior Management and Monitoring Program, Behavior Assessment and Monitoring, Use of Restraints and Unmanageable Residents, Falling Leaf Program (revised for residents at risk for falls), Side Rail Evaluation on Admission and Quarterly, Resident Rights, Guidelines for Nursing Procedures, Accident and Supervision. The Abuse Investigation policies included Reporting Abuse to Facility Management, Resident to Resident Altercation, and Abuse Investigations. The facility provided evidence of mandatory in-service education and training to all staff on Abuse Prevention, Resident Safety, Resident Rights, and Behavior Management. Random interviews with multidisciplinary staff conducted during the revisit from June 4 through June 5, 2012, confirmed they had received in-services related to abuse prevention, resident safety, resident behavior, and resident rights. The facility will remain out of compliance at an "F"	F 501	behaviors that would need psychiatric consultation and behavioral management. These policies include Behavior Assessment and Monitoring, use of Restraints and Unmanageable Residents. Residents admitted with a history of impaired cognition, problematic behaviors, or mental illness will have a Geriopsych Practitioner Consult. This was addressed in the revised Behavior Assessment and Monitoring Policy. Policies were approved by Medical Director and QA Committee on 5/27/12. In-services given on the above policies to all RN's, LPN's, CNA's, by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until in-services are complete. DON/RN will oversee in-services and report to QA/PI. Exhibit # 10 In-services were conducted on revised Behavior Management Policies and Guidelines for Notification of Physician for Problematic Behaviors and other issues that address residents not	

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		F 501	responding satisfactorily to treatments. These in-services were conducted on 5/28/12 & 5/29/12 by DON and RN/BSN. Inservices given to all RN's, LPN's, CNA's, by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until in-services are complete. DON/RN will oversee in-services and report to QA/PI. The Administrator and DON reviewed the Geropsych contact to ensure every other week visits could be provided to address residents with impaired cognition, problematic behavior or mental illness. This was confirmed on 5/18/12 by the Administrator. A Falls Prevention Program called The Falling Leaf Program was developed by the interdisciplinary team in January 2012 and Physical Therapy is responsible for this program. This has been reviewed and revised on 5/27/12 to provide staff and interdisciplinary team members with an approach to	

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		F 501	evaluating and identifying appropriate interventions. New forms and revised process for investigating falls have been developed and implemented 5/28/12. Fall checklist, post fall Nursing Assessment, post Fall Investigation, Occurrence Investigation Statement were approved by the DON, Administration and Medical Director on 5/28/12. Beginning 5/28/12 the Physical Therapist began screening residents with falls. The revised post Fall Investigation Form has possible Preventative Measures and suggested interventions that can aid licensed staff with implementing appropriate interventions. Also Fall Prevention and Potential Interventions and Strategies for Reducing the Risk for Falls were posted at the Nursing Station as a resource for selection of interventions if a fall occurs. This was done 5/29/12 by DON. The Falls Prevention Program includes a quarterly assessment of resident rooms and bath equipment conducted by maintenance staff for needed repairs. This assessment	

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		F 501	was begun January 2012 and revised 05/29/2012 to capture the appropriate documentation for repairs. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's. Staff not in attendance will not be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. The newly created falls checklist provides the notification as a reminder to the staff to PT of falls. The Falls Prevention and Potential Interventions was placed at nurses on 5/28/12 and inserviced to nurses and others, 5/28/12-5/30/12 by DON and RN/BSN. The DON is responsible for the overall Falls Prevention Program, effective 5/29/2012. Exhibit # 21 The Accident and Incidents Clinical Protocol policy for conducting Neuro checks following incidents where residents may have suffered head injury during the fall or an un-	

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		F 501	witnessed fall, was revised to call the Physician and obtain orders for frequency of Neuro checks. All residents experiencing falls will be monitored for 72 hours including Neuro checks as ordered by physician. DON or designee will monitor this process effective 5/16/12. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 20 The Accident and Incidents Clinical Protocol policy for conducting Neuro checks following incidents where residents may have suffered head injury during the fall or an un-witnessed fall, was revised to call the Physician and obtain orders for frequency of Neuro checks. All residents experiencing falls will be monitored for 72 hours including	

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		F 501	Neuro checks as ordered by physician. DON or designee will monitor this process effective 5/16/12. Inservices given 5/27/2012-5/30/2012 to all RN's, LPN's, CNA's, Housekeeping, Dietary, Social Worker, Maintenance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. Exhibit # 28 Those residents identified as being restrained by the use of side rails, Geri chairs, merry-walker or specialized wheelchair received a pre-restraint assessment and an informed consent obtained. This process was begun on 5/15/12 and was completed on 5/29/12 with Medical Director and DON approval. Exhibit # 9	

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		F 501	2) The following policies or procedures have been changed to address these deficient practices: Use of Restraints Behavior Assessment and Monitoring Side rail Evaluation on Admission and Quarterly Abuse Investigation/Seclusion Resident Rights/ Guidelines for all Nursing Procedures Accident and Supervision Exhibit # 10 On 5/29/12 Medical Director attended QA Committee to approve any policies or process changes that needed to be addressed. He was also available for any residents' issues that nurses and office may have had or orders needing signatures. On 5/27/12 the Medical Director made rounds, assessed and evaluated all residents with psychoactive medications or residents with behavior diagnoses. This evaluation was also documented in the Medical Record 5/27/12.	

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		F 501	**3)** The medical director will be informed of all monitoring concerning the deficiencies stated in the 2567 either individual reporting or at the quarterly QAPI committee meeting beginning 5/27/12. The DON or designee will monitor all behaviors weekly to ensure residents receive appropriate care. A list of residents biweekly by Geriopysch Services, will provide to the DON, beginning 5/31/12. DON will monitor residents who have consultation from outside providers monthly. Restraints will be monitored weekly for four weeks until process is in place and functioning efficiently, then quarterly thereafter. Abuse allegations will be logged as received and investigated 24-72 hours, effective 5/15/2012. The DON/MDS Coordinator/ PT will monitor all falls effective 5/29/12. The DON/designee will monitor all restraints assessed and ordered by physician to ensure that all residents	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING _____ B. WING _____	R 06/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	**114 CAMPUS DRIVE DAYTON, TN 37321**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFFICIENCIES	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		F 501	are safe by utilizing the least restrictive measures possible. This will be monitored for three months, beginning 6/1/12, and reevaluate at that time if monitoring needs to continue with approval from the QAPI Committee. The DON will monitor all residents to ensure the absence of all forms of abuse, including involuntary seclusion. This was begun on 5/29/12 and will continue indefinitely. **4)** The DON will report the outcomes of abuse, behavior management, delays in medical care and restraint monitoring to the quarterly QAPI Committee and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 501	Continued From page 93 level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur, and the facility's corrective measure would be reviewed and evaluated by the Quality Assurance Committee.	F 501		
{F 504} SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a physician order for a laboratory test for one resident (#1) of twenty-seven residents reviewed. The findings included: Resident #1 was admitted to the facility on July 8, 2008, with diagnoses including Quadriplegia, Mood Disorder, Seizure Disorder, and Bipolar Disorder. Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Interview with the Nursing Home Administrator (NHA) on May 7, 2012, at 1:50 p.m., in the NHA office, revealed a urine drug screen was completed on the resident on May 3, 2012,	{F 504}	**F 504 483.75(j)(i)(2)(i) Lab Services Only When Ordered by Physician** **Resident #1** 1) On 5/15/12, the DON conducted an in-service with all RNs and LPNs on the "Request for Diagnostic Services-Lab, X-Ray" policy. The policy, "Request for Diagnostic Services-Lab, X-Ray" was placed on the bulletin for quick reference on 6/1/12 to reinforce the in-service conducted on 5/15/12. Any RN or LPN who have not attended an in-service on "Request for Diagnostic Services-Lab, X-Ray", cannot work until they have attended an in-service. 2) On 5/29/12, all other residents who had lab work during the month of May were audited to check for physician orders by ADON. This policy "Request for Diagnostic	6/6/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 504}	Continued From page 94 without the resident's knowledge. Medical record review of the Physician Orders for May 2012, revealed no Physician Order for a drug screen. Interview with the Director of Nursing (DON) on May 9, 2012, at 9:10 a.m., in the front lobby, confirmed the facility completed a urine drug screen on the resident without a Physician Order. C/O #27265 #28092	{F 504}	Services-Lab, X-Ray" will be in-serviced quarterly for the next six months beginning 6/1/12. 3) The DON/ADON will monitor all lab work weekly to ensure a physician order is present beginning 5/15/12. This was begun on 6/1/12 and will continue weekly for six weeks, until satisfactory compliance has been achieved.	
{F 507} SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to file laboratory results on the clinical record for one resident (#1) of twenty-seven residents reviewed. The findings included: Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Interview with the Nursing Home Administrator (NHA) on May 7, 2012, at 1:50 p.m., in the NHA	{F 507}	4) The DON will report the outcomes of lab monitoring to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

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{F 504}	Continued From page 94 without the resident's knowledge. Medical record review of the Physician Orders for May 2012, revealed no Physician Order for a drug screen. Interview with the Director of Nursing (DON) on May 9, 2012, at 9:10 a.m., in the front lobby, confirmed the facility completed a urine drug screen on the resident without a Physician Order.	{F 504}		
{F 507} SS=D	C/O #27265 #28092 483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to file laboratory results on the clinical record for one resident (#1) of twenty-seven residents reviewed. The findings included: Medical record review of the Minimum Data Set (MDS) dated March 15, 2012, revealed the resident scored fifteen of fifteen on the Brief Interview for Mental Status (BIMS) indicating intact cognitive skills and no memory impairment. Interview with the Nursing Home Administrator (NHA) on May 7, 2012, at 1:50 p.m., in the NHA	{F 507}	**F 507 483.75(j)(2)(iv) Lab reports in record-Lab Name/Address** **Resident #1** **1)** The DON reviewed the policy concerning placement of lab reports in the resident's medical record within 7 days. The DON conducted an in-service with all RN's and LPN's that all tests, when ordered by the physician must be placed in chart within 7 days. **2)** On 5/15/12, all other residents who had lab work completed was checked for results in medical results. This policy was in-serviced with all RN's and LPN's on 5/22/12 by DON. Beginning,6/1/12, all labs will be placed in chart within 7 days. Inservice on Physician Order and Notifying resident or POA will be	6/6/12

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{F 507}	Continued From page 95 office, revealed a urine drug screen was completed on the resident on May 3, 2012, without the resident's knowledge and the resident was not aware of the results. Medical record review of the Physician Orders for May 2012, revealed no Physician Order for a drug screen and no laboratory results for a urine drug screen on the clinical record. Interview with the Director of Nursing (DON) on May 9, 2012, at 9:10 a.m., in the front lobby, confirmed the facility completed a urine drug screen on the resident and the results were not on the clinical record. C/O #27265 #28092	{F 507}	conducted quarterly for 6 months by DON. 3) The DON or designee will monitor all lab work ordered to ensure all lab work is placed in the chart in a timely manner, beginning 5/15/12. This policy will be in-serviced quarterly for the next six months beginning 6/1/12. The DON or designee will monitor lab work ordered by physician to ensure that all lab work will be placed in the residents chart in a timely manner. This was begun on 5/15/12 and will continue weekly for six weeks, then as needed to ensure compliance has been achieved. 4) The DON will report the outcomes to the next quarterly QAPI Committee and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
{F 519} SS=D	483.75(n) TRANSFER AGREEMENT WITH HOSPITAL In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.	{F 519}		

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{F 519} SS=D	C/O #27265 #28092 483.75(n) TRANSFER AGREEMENT WITH HOSPITAL In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.	{F 519}	**F 519 483.75(n) Transfer Agreement with Hospital** 1) Upon becoming aware of the need of a hospital contract, the Administrator negotiated a transfer agreement for hospital services with a local hospital on 6/1/12. 2) The Administrator reviewed all contracts to ensure all patient contracts were viable. 3) The Administrator will biannually review all contracts for validity, effective 6/1/12.	6/6/12

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{F 519}	Continued From page 96 The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on facility documentation and interview the facility failed to have a written transfer agreement with a hospital. The findings included: Review of facility documentation requested for extended survey on May 15, 2012, revealed no written transfer agreement between the facility and a hospital for transfer of residents if medically appropriate. Interview with the Administrator and the Director of Nursing in the physical therapy room on May 15, 2012, at 6:00 p.m., confirmed no agreement could be provided.	{F 519}	4) The Administrator will report quarterly to the QAPI committee on any changes in contracts or additions of contracts, and ultimately to the Board meeting quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		

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{F 519}	Continued From page 96 The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on facility documentation and interview the facility failed to have a written transfer agreement with a hospital. The findings included: Review of facility documentation requested for extended survey on May 15, 2012, revealed no written transfer agreement between the facility and a hospital for transfer of residents if medically appropriate. Interview with the Administrator and the Director of Nursing in the physical therapy room on May 15, 2012, at 6:00 p.m., confirmed no agreement could be provided.	{F 519}		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520	**F520 483.75 (o)(i) QA Committee Members/Meet Quarterly/ Plan** 1) The Quality Assurance Plan was reviewed and revised by the DON and Healthcare Consultant on 5/28/12. This revised plan, Quality Assessment/ Performance Improvement Plan was presented at	6/6/12

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F 520	Continued From page 97 committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the Quality Assurance (QA) Committee attendance records, facility investigation reviews, facility policy reviews, observations, and interviews the facility failed to ensure the Quality Assurance committee identified resident's safety, falls , behavior management care planning, mental health, rehabilitative services, abuse, and injuries of unknown origin as potential areas for quality improvement. The facility's failure to review data and formulate/implement improvement plans placed all the residents in Immediated Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).	F 520	the 5/29/12 QA Committee for approval by members. Exhibit # 25 A revised QA standing agenda was developed by the Healthcare Consultant to ensure quality issues are addressed and standing reports are reviewed quarterly for any issues with resident care. This standing agenda was approved 5/29/12 by the QA Committee. Exhibit # 26 Trending Reports were developed by Health Care Consultant to use for reporting incidents and including fall, abuse, medication errors, performance indicators, infection control, and wound reports. This was completed on 05/29/2012 to be used at the next QI meeting. Exhibit # 14 2) The DON reviewed the deficiencies stated in the 2567 to identify in-services needed and to address each tag cited. Inservices given to all RN's, LPN's, CNA's,	

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F 520	Continued From page 98 The facility provided a Credible Allegation of Compliance on May 30, 2012. A revisit conducted on June 4 - 5, 2012, revealed the corrective actions implemented on May 30, 2012, removed the Immediate Jeopardy. Non-compliance continues at an "F" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, ancillary contract review, and interviews with facility staff including the administrative staff. Medical record review of the care plans for the residents on the follow-up sample revealed the care plans had been revised to include appropriate interventions for managing behaviors and safety concerns. Observation of the residents throughout the follow-up visit revealed no residents were involuntarily secluded; and there were no observations of resident altercations. Facility staff provided diversion activities to behavioral and wandering residents. The facility environment was calm with planned activities taking place. The facility provided evidence an independent, Healthcare Consultant, had been retained to assist the facility in systems management to improve the quality of care for the residents, and provide staff education in areas deemed lacking. The Healthcare Consultant was introduced to the	F 520	Housekeeping, Dietary, Social Worker, Maintance, Activities Director, Laundry, PT, Office Staff, Administrator, Feeding Assists by DON and RN/BSN from 5/27/12-5/30/12. Staff not in attendance will no be able to work until inservices are complete. DON/RN will oversee inservices and report to QA/PI. 3) The DON has developed a standing agenda to ensure no items are missed. Developed trending reports for accidents/incidents, wound care, infection control, and behavior management. 4) The DON will report the outcomes of monitoring of quality of care provided through abuse, behavior management, delays in medical care and restraint monitoring, and other indicators identified to the quarterly QAPI Committee and ultimately the Administrator will report to the Board meeting quarterly. The next scheduled QAPI Committee meeting is 6/20/12.	

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F 520	Continued From page 99 survey team on June 5, 2012, at 8:30 a.m., in the therapy room. The facility provided evidence the Medical Director was educated by the Healthcare Consultant/RN on the importance of recording abuse allegations, and investigating and reporting allegations in a timely manner. The facility provided evidence of the Quality Assurance/Performance Improvement Plan had been revised to include a standing agenda for identifying quality issues with falls, incidents, abuse, medication errors, infection control, wounds, and other performance indicators. The facility provided evidence of the review and revision of the facility's Abuse Prevention Program, approved by the Medical Director at the Quality Assurance meeting conducted on May 29, 2012. Continued review of the evidence revealed the revised program contained detailed information on Resident-to-Resident Altercations, Abuse Investigations, Reporting Abuse to Facility Management, and a 3-page investigative worksheet for data gathering and evaluation titled, Resident Abuse Investigation Report Form. The facility provided evidence the Medical Director reviewed, revised, and approved the following facility policies on May 27, and May 29, 2012. Abuse Investigation/Seclusion, Behavior Management and Monitoring Program, Behavior Assessment and Monitoring, Use of Restraints and Unmanageable Residents, Falling Leaf Program (revised for residents at risk for falls), Side Rail Evaluation on Admission and Quarterly, Resident Rights, Guidelines for Nursing	F 520		

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F 520	Continued From page 100 Procedures, Accident and Supervision. The Abuse Investigation policies included Reporting Abuse to Facility Management, Resident to Resident Altercation, and Abuse Investigations. The facility provided evidence of mandatory in-service education and training to all staff on Abuse Prevention, Resident Safety, Resident Rights, and Behavior Management. Random interviews with multidisciplinary staff conducted during the revisit from June 4 through June 5, 2012, confirmed they had received in-services related to abuse prevention, resident safety, resident behavior, and resident rights. The facility will remain out of compliance at an "F" level until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur, and the facility's corrective measure would be reviewed and evaluated by the Quality Assurance Committee.	F 520		